

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 04380 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 days
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Rural-Keedysville, Md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

Dale Herman Abbott

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife _____
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Sept. 16, 1943
 8. AGE: Years 3 Months 7 Days 20 If less than one day _____ hrs. _____ min.

9. Birthplace Hagerstown-Washington-Maryland
(Town, county, and state)10. Usual occupation None

11. Industry or business _____

12. Name Austin Lancelot Abbott13. Birthplace Keedysville, Md. R. F. D. #114. Maiden name Irene Blanche Hardy15. Birthplace Chestnut-Grove, Maryland16. Informant Austin L. AbbottAddress Keedysville, Md. R. F. D. #117. Burial Date thereof May 9 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rohrersville,Location Rohrersville, Md18. Funeral director R. I. EarnshawAddress Keedysville, Md19. May 8, 1947 Registrar Chas. H. Bowers
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6 1947 at 7:45 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 5 1947 to May 6 1947
and that I last saw him alive on May 5 1947Immediate cause of death Acute peritonitisDue to Acute gangrenous appendixOther conditions _____
(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.22. VIOLENCE: If death was due to external causes, till in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? (City or town) (County) (State)Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work? _____23. SIGNATURE G. W. Bowers M. D. or other 5/6/47
Address Rohrersville Date signed _____

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 10 1947
BUREAU V 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Poole

04381

93e

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 30 Years
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 14 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 14 So. Locust St.
 (If rural, give LOCATION)
None
 2.(a) If veteran, name war None

3. (a) FULL NAME

WILLIAM HENRY ARTZ

3. (b) Social Security Number

214-09-8739

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Marg. E. Mills
 6.(c) If alive, give age 58 years
 7. Birth date of deceased (mo., day, yr.) February 15 1879
 8. AGE: Years 68 Months 2 Days 26 It less than one day hrs. min.

9. Birthplace Bakersville Wash. Co. Md.
 (Town, county, and state)
 10. Usual occupation Laborer
 11. Industry or business General
 12. Name Thos. J. Artz
 13. Birthplace Bakersville Md.
 14. Maiden name Susan Avery
 15. Birthplace Boonsboro Md.

16. Informant Mrs. Margaret E. Artz
 Address Hagerstown Md.

17. Burial 5/13/47
 (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
 Cemetery or crematory Rest Haven Cemetery
 Location Hagerstown Md.

18. Funeral director Andrew K. Coffman
 Address Hagerstown Md.

19. May 13 1947 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

Noon

20. DATE OF DEATH May 11 1947 19 47 at 13 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1st 19 47 to May 11th 19 47
 and that I last saw him alive on May 10th 19 47

Immediate cause of death Arterio sclerosis
bronchiectasis
acute congestive
myocardial decompensation
 DURATION 5 yrs.
5 yrs.
2 yrs.
 Other conditions
 (Include pregnancy within 3 months of death)

Major findings of operations
 Date of op.
 Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Ernest J. Poole MD
 M. D. or other
 Address Hagerstown Md Date signed 5-12-47

RECEIVED

MAY 15 1947

BUREAU V A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Victor Miller

64382

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 10 Years
 Hospital, institution, or street address where death occurred:
21 E. Antietam St.
 How long in hospital or institution? --

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 21 E. Antietam St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

WALTER PRICE BARNETT

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Namie
 6.(c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) June 4, 1865

8. AGE: Years 81 Months 11 Days 21 If less than one day
 hrs. min.

9. Birthplace Downsville, Washington Co. Md.
 (Town, county, and state)

10. Usual occupation Livery Stable Owner

11. Industry or business Self Employer

FATHER 12. Name Washington Barnett
 13. Birthplace Wilson Md.

MOTHER 14. Maiden name Mary Hane Crowe
 15. Birthplace Downsville Md.

16. Informant Mrs. Nannie Barnett
 Address Hagerstown Md.

17. Burial Date thereof 5/27/47
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory River View Cemetery
 Location Williamsport Md.

18. Funeral director Andrew K. Coffin and
 Address Hagerstown Md.

19. May 26, 47 Blount Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24, 19 47, at 8:00P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
47 to 5/24/47
 and that I last saw him alive on 5/24/47

Immediate cause of death Carcinoma of Stomach (?)

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. Victor Miller
 DR. VICTOR D. MILLER M. D. or other

Address 131 W. WASHINGTON, ST Date signed 5/25-47
 HAGERSTOWN, MD.

RECEIVED

MAY 28 1947

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Write correct age in correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

04383

304

1. PLACE OF DEATH:

County WashingtonCity or town Hancock
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hancock
(If outside city or town limits, write RURAL and give nearest town)Street No. Main Street
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Georgia Higgs Beard

3. (b) Social Security Number

4. Sex Female5. Color or race White6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Frank R. Beard

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) June 4, 18588. AGE: Years 88 Months 11 Days 8 If less than one day _____ hrs. _____ min.9. Birthplace Hancock, Wash. Co., Md.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business _____

12. Name Henry Higgs13. Birthplace Buckeystown, Fred. Co., Md.14. Maiden name Susan Manning15. Birthplace Maryland16. Informant Frank R. Beard, Jr.Address Hancock, Md.17. Burial Date thereof May 12, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetary or crematory St. Thomas EpiscopalLocation Hancock, Md.18. Funeral director Charles R. BastAddress Hancock, Md.19. 5/14/47 Registrar Julia Heller

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-12-47 at 4:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1936, to 5-11-47 and that I last saw him alive on 5-11-47Immediate cause of death Coronary Arteriosclerosis - Renal Disease

Due to _____

Due to _____

Other conditions Senile Debility

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Herbert R. Lohman M.D.Address Hancock, Md. Date signed 5-14-47

RECEIVED

MAY 16 1947

BUREAU 8

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

04384

1. PLACE OF DEATH:

County... Washington

City or town... Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 years

Hospital, institution, or street address where death occurred:

330 N. Jonathan Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Washington

City or town... Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No... 330 N. Jonathan Street

(If rural, give LOCATION)

2.(a) If veteran, name war... World War I

3. (a) FULL NAME

Clinton Senem Beckett

3. (b) Social Security Number

232-01-6028

4. Sex

Male

5. Color or race

Negro

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Louise Beckett

6. (c) If alive, give age... 51 years

7. Birth date of deceased (mo., day, yr.)

September 1, 1890

8. AGE:

Years

Months

Days

If less than one day

56

8

11

hrs.

min.

9. Birthplace

Cheriton, Virginia

(Town, county, and state)

10. Usual occupation

Laborer - Victor Products

11. Industry or business

Clinton Beckett

12. Name

Cheriton Virginia

13. Birthplace

Virginia James

14. Maiden name

Cheriton Virginia

15. Birthplace

Mrs. Louise Beckett

16. Informant

330 N. Jonathan Street

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof...

5/15/47

(month, day, year)

18. Cemetery or crematory

Rose Hill Cemetery

19. Location

Hagerstown, Md.

20. Funeral director

Valham H. Downey

21. Address

291 Frederick St. Hagerstown

22. May 15, 47

(Date rec'd by registrar)

23. Registrar

Charles Bowers

MEDICAL CERTIFICATION

20. DATE OF DEATH... 12 May 1947 at about 9 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

21 Month 1947 to 12 May 1947

and that I last saw him alive on 19...

Immediate cause of death

Coronary atherosclerosis
(with acute infarction) 92%

Due to... Sepsis

Due to...

Due to...

Due to...

Due to...

Due to...

Due to...

Due to...

Due to...

Due to...

Due to...

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Due to...

Due to...

Due to...

Due to...

DURATION

5 weeks

35 years

35 years

35 years

35 years

35 years

35 years

35 years

35 years

35 years

35 years

35 years

35 years

35 years

35 years

35 years

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35 years

35 years

35 years

Other conditions: Hypertension, Coronary

Vascular disease

(Include pregnancy within 8 months of death)

Major findings of operations...

Date of op. ...

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Signature... R. J. Layman, M.D.

Address... 100 Frederick St. Hagerstown, Md.

Date signed... May 15, 1947

Signature... R. J. Layman, M.D.

Address... 100 Frederick St. Hagerstown, Md.

Date signed... May 15, 1947

Signature... R. J. Layman, M.D.

Address... 100 Frederick St. Hagerstown, Md.

Date signed... May 15, 1947

Signature... R. J. Layman, M.D.

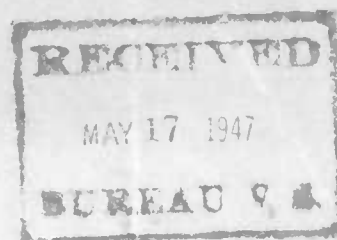
Address... 100 Frederick St. Hagerstown, Md.

Date signed... May 15, 1947

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

04385

300

1. PLACE OF DEATH:

County WashingtonCity or town Sharpsburg
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Sharpsburg
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

Kenneth William Bowers

3. (b) Social Security Number

214-09-0955

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Nora Benner6. (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.)

May 6, 1906

8. AGE:

40 Years

Months

11

Days

26

If less than one day

hrs.min.9. Birthplace Sharpsburg, Wash., Maryland
(Town, county, and state)10. Usual occupation Operated Filling Station11. Industry or business Filling Station

FATHER

12. Name Samuel Bowers13. Birthplace Sharpsburg, Maryland

MOTHER

14. Maiden name Elsie Colbert15. Birthplace Sharpsburg, Maryland16. Informant Nora Benner BowersAddress Sharpsburg, Maryland17. Burial Date thereof May 4, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mountain View CemeteryLocation Sharpsburg, Maryland18. Funeral director Edith V. LeafAddress Williamsport, Maryland19. May 3 1947
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1 1947, at 5 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 22 1947 to May 1 1947and that I last saw him alive on May 1 1947

Immediate cause of death

Melanocarcinoma

DURATION

6 mon.Due to Primary site on back. Self-inflicted

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations A mole was removedDate of op. six months previous

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury

Injured at work?

23. SIGNATURE G. W. Lefkowitz M.D.

M. D. or other

Address Bowmans Date signed 5/2/47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 043862

1. PLACE OF DEATH:
County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
1004 Hamilton Blvd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1004 Hamilton Blvd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Lida Bradley 3. (b) Social Security Number None

4. Sex Female 5. Color or race White 6. (a) Single, married, or divorced Married

6. (b) Name of husband or wife John J. Bradley

7. Birth date of deceased (mo., day, yr.) December 18, 1881 6. (c) If alive, give age _____ years

8. AGE: 65 years 4 Months 21 Days If less than one day _____ hrs. _____ min.

9. Birthplace Martinsburg - Berkley - W. Va.
(Town, county, and state)

10. Usual occupation Home Duties

11. Industry or business

FATHER 12. Name Joseph A. Englerth
13. Birthplace Germany

MOTHER 14. Maiden name Susan Cox
15. Birthplace ----- Penn.

16. Informant John J. Bradley
Address 1004 Hamilton Blvd. Hagerstown, Md.

17. Burial Burial Date thereof May 22, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Corpus Christi Cemetery
Location Chambersburg, Pa.
Fred W. Kraiss

18. Funeral director Fred W. Kraiss
Address Hagerstown, Md.

19. May 10, 47 Phaeth Boward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9, 1947 19 9:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 9 19 47 to May 9 19 47
and that I last saw her alive on May 9, 1947 19 47

Immediate cause of death Pulmonary Edema DURATION 3 hrs

Due to Coronary - Arteriosclerotic Heart Disease Pulmonary

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Salmon M. Welty, M.D.
Address Hagerstown, Md. Date signed 5-10-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 13 1947
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

160C

04387

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County... Washington
 City or town... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Washington
 City or town... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 335 Ridge Avenue
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Terry Lee Brant

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) May 19, 1947 6. (c) If alive, give age _____ years

8. AGE: Years -- Months -- Days -- If less than one day 15 hrs. -- min.

9. Birthplace Hagerstown, Wash. Co., Md.
 (Town, county, and state)

10. Usual occupation None

11. Industry or business

12. Name Gerald Brant13. Birthplace Hagerstown, Md.14. Maiden name Doratha Wyand15. Birthplace Hagerstown, Md.16. Informant Gerald BrantAddress 335 Ridge Avenue- Hagerstown, Md.17. Burial Date thereof May 20-47

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetary or crematory Rose Hill CemeteryLocation Hagerstown, Md.18. Funeral director Fred W. KraissAddress Hagerstown, Md.19. May 20, 47 Registrar G. H. Baverly

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19, 1947 19 47, at 3:05 P. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 19, 1947 to May 19, 1947and that I last saw him alive on May 19, 1947Immediate cause of death Birth injury of brain, unspecifiedDURATION 15 hoursDue to unspecifiedDue to unspecifiedOther conditions None

(Include pregnancy within 3 months of death)

Major findings of operations No operation

Date of op. _____

Autopsy results As autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

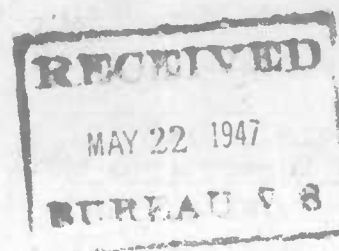
Means of injury _____ Injured at work? _____

23. SIGNATURE Ra. Bee M. D. or other _____Address Hagerstown Md Date signed 5/20/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown Maryland
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

221 South Potomac St.
Hagerstown Md

How long in hospital or institution?

3. (a) FULL NAME

Buleah Grace Brashears

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Thomas Walter Brashears

7. Birth date of

deceased (mo., day, yr.)

July 19 1883

8. AGE:

Years

Months

Days

If less than one day

63101

hrs.

min.

9. Birthplace

Sharpsburg Md

(Town, county, and state)

10. Usual occupation

housewife

11. Industry or business

homeFATHER
MOTHER

12. Name

George Grey

13. Birthplace

Sharpsburg Md

14. Maiden name

Mary Gardner

15. Birthplace

Pa

16. Informant

Thomas Walter Brashears

Address

221 S Potomac St Hagerstown Md

17.

Burial

(Burial, cremation, or removal, Which?)

Date thereof

May 20 1947

Cemetery or crematory

Mt. View

Location

Sharpsburg Md

18. Funeral director

Edith V. Leaf

Address

Williamsport Md

19.

May 20. 47
(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
Hagerstown Md.

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

221 S. Potomac

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 18 1947 at 12 20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 18 1947 to 19

and that I last saw h.

ery alive on May 18 1947

Immediate cause of death

Acute Cardiac Failure

DURATION

10 min

Due to

Coronary Occlusion

Due to

Hypertensive Cardio Vascular disease

Other conditions

Generalized Arterio-sclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: if death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

injured at work?

23. SIGNATURE

Robert V. L. Campbell M.D.

M. D. or other

Address

Hagerstown Md

Date signed

May 19/47

RECEIVED

MAY 22 1947

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13/a

04389

CERTIFICATE OF DEATH

00

Reg. Dist. No. 303

1. PLACE OF DEATH:

County Washington Co.City or town Hagerstown, Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 days

Hospital, institution, or street address where death occurred:

Washington Co. Hospital HagerstownHow long in hospital or institution? 2 days

3. (a) FULL NAME

Charles A. Buchbinder

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Jane Hoch Brechiel6. (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.)

Oct 21 - 1877

8. AGE:

Years

Months

Days

If less than one day

69615

hrs.

min.

9. Birthplace

Cumberland Co Pa.
(Town, county, and state)

10. Usual occupation

Broom maker

11. Industry or business

John Brechiel

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Mrs. James H. Brechiel

Address

Mercersburg Pa R 2

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof May 9 - 47
(month) (day) (year)

Cemetery or crematorium

Green Hill

Location

Mercersburg Pa.

18. Funeral director

McKininger

Address

Mercersburg, Pa.

19. May 8.

19. 47

(Date rec'd by registrar)

Blair H. Bowers

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Penn

County

Franklin

City or town

Mercersburg Pa
(If outside city or town limits, write RURAL and give nearest town)

Street No.

Rural R 2
(If rural, give LOCATION)

2. (a) If veteran, name war

210

MEDICAL CERTIFICATION

20. DATE OF DEATH

5/619 47 at 6:53 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2/119 47

to

5/619 47

and that I last saw him alive on

5/619 47

Immediate cause of death

ArterioscleroticCardio-vascular - renal disease& congestive failure

DURATION

2 weeks

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. C. Lewis

M. D. or other

Address

Greensboro, Pa.

Date signed

5/7/47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

THE BUREAU OF VITAL STATISTICS

MINISTRY OF HEALTH

Dr. Wm B. Newell

RECEIVED

MAY 10 1947

BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (3d)

CERTIFICATE OF DEATH

Reg. Dist. No. 302

04390

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death 2 Years
 Hospital, institution, or street address where death occurred:
117 South Potomac St.
 How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 117 South Potomac St
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

MRS BARBARA ANN BURGER

3. (b) Social Security Number

None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced	
Female	White	Widow	
6. (b) Name of husband or wife <u>Fred. G.</u>			
6. (c) If alive, give age <u>-</u> years			
7. Birth date of deceased (mo., day, yr.) <u>October 22 1858</u>			
8. AGE:	Years	Months	Days
	88	7	7
If less than one dayhrs.min.			
9. Birthplace <u>Clear spring Wash. Co. Md.</u> (Town, county, and state)			
10. Usual occupation <u>Housewife</u>			
11. Industry or business <u>Own Home</u>			
FATHER	12. Name <u>John Ernst</u>		
	13. Birthplace <u>Germany</u>		
MOTHER	14. Maiden name <u>No Record</u>		
	15. Birthplace <u>Germany</u>		

16. Informant Clarence C. Burger
 Address Hagerstown Md.

17. Burial Burial Date thereof 5/31/47
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Rose Hill Cemetery
 Location Hagerstown Md.

18. Funeral director Andrew K. Coffman
 Address Hagerstown Md.

19. May 30. 1947 Chas. Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29 1947 19..... at 4.30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 12, 1943 to May 29, 1947
 and that I last saw him alive on May 27, 1947

Immediate cause of death Hypertensive Cor. Arteriosclerosis
Acute Cordic Paralysis

Due to 4 yrs.
4 days

Other conditions -

(Include pregnancy within 3 months of death)

Major findings of operations - Date of op. -

Autopsy results No
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide X Date of X
 Where did injury occur? X (City or town) X (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury - Injured at work?

23. SIGNATURE W. Howard Yeager M. D. or other
 Address Hagerstown Md Date signed 5-29-47

MARGIN RESERVED FOR BINDING

9-45-15M

VS AIB

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 2 1947
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH:

County... WashingtonCity or town... Breathedsville, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? from 3/7/47

Hospital, institution, or street address where death occurred:

Md. State Reformatory for MalesHow long in hospital or institution? Since 3/7/47

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... WorcesterCity or town... Snow Hill, Maryland

(If outside city or town limits, write RURAL and give nearest town)

Street No. Route #2, Box 16

(If rural, give LOCATION)

2.(a) If veteran, name war... World War II

3. (a) FULL NAME

COLLINS, Earl

3. (b) Social Security Number

unknown

4. Sex

male

5. Color or race

negro

6. (a) Single, married, widowed, or divorced

single6. (b) Name of husband or wife... single

7. Birth date of

deceased (mo., day, yr.) March, 6, 1924

8. AGE: Years Months Days It less than one day

23216

.....hrs.min.

9. Birthplace Sharon Hill, Pa.

(Town, county, and state)

10. Usual occupation... laborer

11. Industry or business

12. Name... Virgil Collins13. Birthplace Snow Hill Md.14. Maiden name... No Record15. Birthplace No Record16. Informant Md. State Reformatory for MalesAddress Breathedsville, Md.17. Burial Date thereof 5/25/47

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Hutts CemeteryLocation Snow Hill Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. May 22 19 47 John H. Bass

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... May 22 19 47 at 3:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

5/21/47 19 47 to 5/22/47 19 47and that I last saw him alive on 5/22/47 19 47

Immediate cause of death

DURATION

Sudden cardiac failure

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Hagerstown Md. Date signed 5/25/47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 27 1947
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Do not correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Wishard

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (4-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 306

1. PLACE OF DEATH:

County Washington
City or town Cascade
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 66 yrs 4 mo 27 days
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Ind County Washington
City or town Cascade
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) if veteran, name war _____

3. (a) FULL NAME

Bertha Fritz

3. (b) Social Security Number

4. Sex Female 5. Color or race W 6. (a) Single, married, widowed, or divorced Widow
6. (b) Name of husband or wife Charles I Fritz
8. (c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) Jan 1 1881

8. AGE: Years 66 Months 4 Days 27 If less than one day _____ hrs. _____ min.

9. Birthplace Sabillasville Ind
(Town, county, and state)

10. Usual occupation House work

11. Industry or business

FATHER 12. Name John Gall
13. Birthplace Germany

MOTHER 14. Maiden name Susan McElain
15. Birthplace Sabillasville Ind

16. Informant John H Fritz
Address Highfield Ind

17. Burial Burial Date thereof 5 31 1947
(Burial, cremation, or removal. Which? (month) (day) (year))

Cemetery or crematory Bethel Cemetery
Near Cascade Ind
Location

18. Funeral director Walter Y Groce
Address Waynesboro Tenn

19. May 29 1947 Geo W. Fugerson
(Date read by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May - 28 1947, at 6:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19____, to May 26 1947
and that I last saw him alive on May - 28 1947

Immediate cause of death _____ DURATION _____
Carcinoma of
Due to Sigmoid - 6 yrs.
Due to _____
Other conditions Rheumatoid arthritis - 10 yrs.
(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work?

23. SIGNATURE Walter H. Groce M.D.
Address Waynesboro Tenn Date signed 5/29/47

RECEIVED
JUN 4 1947
BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 305

04393

1. PLACE OF DEATH:

County Washington
 City or town Boonsboro Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 34 years
 Hospital, institution, or street address where death occurred:
Boonsboro Md. R. 2
 How long in hospital or institution? at home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Boonsboro
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Boonsboro Md. R. 2
 (If rural, give LOCATION)
 2.(a) If veteran, name war no

3. (a) FULL NAME

John Jacob Foreman

3. (b) Social Security Number

219-12-0450

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced divorced
 6. (b) Name of husband or wife divorced
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) July-13-1901
 8. AGE: Years 45 Months 9 Days 23 If less than one day _____ hrs. _____ min.

9. Birthplace Connellsville Penna.
 (Town, county, and state)
 10. Usual occupation Miner
 11. Industry or business _____

12. Name Jacob Foreman
 13. Birthplace Martinsburg W. Va.
 14. Maiden name Sarah Goukins
 15. Birthplace Fred. Co. Md.

16. Informant Gerald Foreman
 Address Boonsboro Md. R. 2
 17. Burial Date thereof May 9, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Green Hill Cemetery
 Location Martinsburg W. Va.

19. Funeral director Wm. J. Bast & Sons
 Address Boonsboro Md.

19. May-9- 19. 47 John J. Bast
 (Date signed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6 19. 47 at 10:00 M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 17 19. 47 to May 6 19. 47
 and that I last saw him alive on April 26 19. 47

Immediate cause of death Cerebral thrombosis
 DURATION 19 days

Due to _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

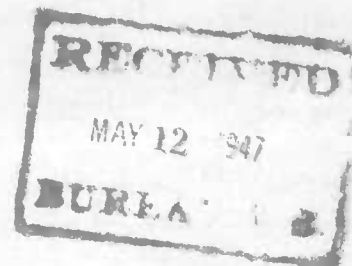
22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE Robert M. M. A M. D. or other _____
 Address Boonsboro Md. Date signed 5/6/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 119 E antietam⁸⁸
P4394
302

1. PLACE OF DEATH:

County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 days
Hospital, institution, or street address where death occurred:
Washington County Hospital
How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Md County Washington
City or town Rural
(If outside city or town limits, write RURAL and give nearest town)
Ben Mar Pa
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Arthur Watson Frayer

3. (b) Social Security Number

None

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married
6. (b) Name of husband or wife Evelyn Myers
6. (c) If alive, give age 57 years
7. Birth date of deceased (mo., day, yr.) Sept. 2, 1882
8. AGE: Years 64 Months 8 Days 27 If less than one day hrs. min.

9. Birthplace Beaver County N. Va
(Town, county, and state)
10. Usual occupation Minister
11. Industry or business

12. Name B. F. Frayer
13. Birthplace N. Va
14. Maiden name Laura Williams
15. Birthplace N. Va

16. Informant Mrs Evelyn M. Frayer
Address Ben Mar Pa

17. Burial Date thereof 6/1/47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or Broad fiding
Location Washington Co. Ind
Walker 74 Lane

18. Funeral director Walter J. HANE
Address 278 Church & Waynesboro Pa

19. May 30, 47 Registrar Charles Bowers
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29 1947, at 47 M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 29 1947 to May 29 1947
and that I last saw him alive on May 29 1947

Immediate cause of death Cerebral thrombosis
DURATION 2 weeks

Due to
Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations None Date of op.

Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide None Date of
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Wm. H. Hower M. D. or other
Address Hagerstown Md Date signed 5/30/47

RECEIVED
JUN 2 1947
BUREAU V.S.

Evidence for the change of
age is shown on
Ex 10x

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Dr. Norment

44

FILM No. G 110 MAY 13 1947

CERTIFICATE OF DEATH

94a

04395

Reg. Dist. No. 302

1. PLACE OF DEATH:

County... Washington

City or town... Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 Days

Hospital, institution, or street address where death occurred:
111 North Street

How long in hospital or institution? --

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 111 North Street
(If rural, give LOCATION)

2.(a) If veteran, name war None

3. (a) FULL NAME

JOHN FENTON GALLION

3. (b) Social Security Number

None

4. Sex Male

5. Color or race White

6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Daisy Gallion

7. Birth date of deceased (mo., day, yr.) July 6, 1870

6. (c) If alive, give age 74 years

8. AGE: Years 76 Months 7 Days 27 If less than one day
76 77 9 27 hrs. min.

9. Birthplace Mt. Lena Wash. Co. Md.
(Town, county, and state)

10. Usual occupation Electrical Work

11. Industry or business M.P. Moller Co.

12. Name William H. Gallion

13. Birthplace Mt. Lena Md.

14. Maiden name Martha Kinsey

15. Birthplace Mt. Lena Md.

16. Informant Mrs. Daisy Gallion

Address Hagerstown Md.

17. Burial Date thereof 5/5/47
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown Md.

18. Funeral director Andrew K. Coffman

Address Hagerstown Md.

19. May 5, 1947 Registrar Charles Bowers

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3, 1947 at 7 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 30, 1947 to May 3, 1947
and that I last saw him alive on May 3, 1947

Immediate cause of death Coronary occlusion DURATION 1 day

Due to

Due to

Other conditions Arteriosclerotic heart disease
(Include pregnancy within 3 months of death)

Major findings of operations None

Autopsy results None Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. Norment M. D. or other

Address Hagerstown Md Date signed 5/5/47

MARGIN RESERVED FOR BINDING

VS A45 9-45-15M

VS A45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 7 1947
BUREAU 73

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

04396

302

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County... Washington
 City or town... Fiddlersburg
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 50 years
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Washington
 City or town... Fiddlersburg
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2. (a) If veteran, name war.....

3. (a) FULL NAME

Annie Garlock

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

William S. Garlock

7. Birth date of deceased (mo., day, yr.)

January 1, 1865

5. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

It less than one day

82420

hrs.

min.

9. Birthplace

Sharpsburg Wash. Md.

(Town, county, and state)

10. Usual occupation

None

11. Industry or business

None

FATHER

12. Name

Unknown

13. Birthplace

It

MOTHER

14. Maiden name

It

15. Birthplace

16. Informant

Mrs. Kaleb Dayhoff

Address

Fiddlersburg Md.

17. Burial

(Burial, cremation, or removal. Which?)

5-24-47

(month) (day) (year)

Cemetery or crematory

Shilo Cemetery

Location

Fiddlersburg Md.

18. Funeral director

Scott F. Minnich & Son

Address

Hagerstown Md.

19. May 23, 47

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... May 21 19 47 8:15a

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 19 19 47 to May 21 19 47and that I last saw him alive on May 20, 1947 19Immediate cause of death... Hemiplegia 7/2/47 48 hrsCardiovascular disease 1 yr

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... W. D. Campbell M. D. or otherAddress... Hagerstown Md. Date signed... 5/21/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 26 1947

BUREAU V B

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr/ Layman

04397

Reg. Dist. No. 302

1. PLACE OF DEATH:

County... WashingtonCity or town... Hagerstown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 Years

Hospital, institution, or street address where death occurred:

833 Brown AveHow long in hospital or institution? ---

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... WashingtonCity or town... Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 833 Brown Ave

(If rural, give LOCATION)

None2.(a) If veteran, name war... None

3. (a) FULL NAME

MRS. GRACE SCOTT GARMAN

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife

John B.

6. (c) If alive, give age... years

7. Birth date of

deceased (mo., day, yr.) March 12 1871

8. AGE:

Years

Months

Days

If less than one day

76211

hrs.

min.

9. Birthplace Sugar Grove Smith Co. Va.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Own Home

FATHER

12. Name

Levi M. Scott

13. Birthplace

Sugar Grove Va.

MOTHER

14. Maiden name

Amanda Edmondson

15. Birthplace

Meadow View Va.

16. Informant

Joseph James

Address

Hagerstown Md.

17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof

5/25/47

(month) (day) (year)

Cemetery or crematory

Damascus Church Cemetery

Location

near Hancock, Fulton Co. Pa.

18. Funeral director

Andrew K. Coffman

Address

Hagerstown Md.

19.

May 24, 47

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23 1947 19... at 2.30 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Cerebral 19 46 to May 23 19 47and that I last saw him alive on May 20 19 47

Immediate cause of death

Cerebral Aneurysm

DURATION

6 years?

Due to

Due to

Other conditions

Sandwich

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Dr. D. Layman, M.D.

M. D. or other

Address

1000 Broadway, Hagerstown, Md.

Date signed

23 May 47

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct and is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 27 1947
BUREAU V B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Dr. Layman

48

CERTIFICATE OF DEATH

Reg. Dist. No. 043802

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 15 Months

Hospital, institution, or street address where death occurred:

1818 Virginia AveHow long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 1718 Virginia Ave

(If rural, give LOCATION)

2.(a) If veteran, name war. None

3. (a) FULL NAME

JASPER NEWTON GIGOUS

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widwoer

6. (b) Name of husband or wife

Mary6. (c) If alive, give age - years

7. Birth date of

deceased (mo., day, yr.) March 4 1864

8. AGE:

Years

Months

Days

If less than one day

8321

hrs.

min.

9. Birthplace Boonsboro Wash. Co. Md.
(Town, county, and state)10. Usual occupation Farmer11. Industry or business Retired12. Name Harrison Gigous13. Birthplace Keedysville Md.14. Maiden name Amanda Thomas15. Birthplace Keedysville Md.16. Informant Paul E. GigousAddress Williamsport Md.17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 5/7/47

(month) (day) (year)

Cemetery or crematory Rose Hill CemeteryLocation Hagerstown Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. May 7. 47 Charles H. Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5 1947 19 47 at 6 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 19 46 to May 5 19 47
and that I last saw him alive on May 4 19 47

Immediate cause of death

Amyotrophic lateral sclerosis

DURATION

Year

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. D. Layman, M.D.
Address 100 Proprietor at Bldg 6 Date signed May 4 1947

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct age especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 9 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Write correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Ditto

04399

Reg. Dist. No. 302

1. PLACE OF DEATH:

County..... Washington
 City or town..... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 days
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 3 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Washington
 City or town..... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 351 Liberty St
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... None

3. (a) FULL NAME

MRS LILLIE HIGGINS GUESSFORD

3. (b) Social Security Number

None

4. Sex..... Female 5. Color or race..... white 6.(a) Single, married, widowed, or divorced..... Widow
 6.(b) Name of husband or wife..... Edward
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.) August 30 1874
 8. AGE: Years..... 72 Months..... 8 Days..... 18 hrs..... min.....

9. Birthplace..... Clearspring Wash. Co. Md.
 (Town, county, and state)
 10. Usual occupation..... Housewife
 11. Industry or business..... Own Home

FATHER 12. Name..... Martin L. Higgins
 13. Birthplace..... Blairs Valley Md.
 MOTHER 14. Maiden name..... Jane Clopper
 15. Birthplace..... Blairs Valley Md.

16. Informant..... Mrs. Simon Hildebrand
 Address..... Hagerstown Md.

17. Burial..... 5/20/47
 (Burial, cremation, or removal, Which?) Date thereof..... (month) (day) (year)
 Cemetery or crematory..... St. Pauls Cemetery
 Location..... near Clearspring Md.

18. Funeral director..... Andrew K. Coffman
 Address..... Hagerstown Md.

19. May 20 19 47 Chas. H. Bowers
 (Date read by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 18 1947 19..... at 10 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 16 - 47 to May 18 - 47
 and that I last saw him alive on May 18 - 47 19.....

Immediate cause of death.....
 Due to.....
 Due to.....
 Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations.....
 Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town)..... (County)..... (State).....
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?

23. SIGNATURE..... Dr. Ditto M. D. Chas. H. Bowers
 Address..... Hagerstown Md. Date signed..... 5/19/47

RECEIVED

MAY 22 1947

BUREAU F B

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Dr. Wells

51

CERTIFICATE OF DEATH

Reg. Dist. No. 362

1. PLACE OF DEATH:

County... Washington
 City or town... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Corner Oak Hill Ave. & Maple Ave.How long in hospital or institution? ---

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... WashingtonCity or town... Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 703 Oak Hill Ave.
(If rural, give LOCATION)2.(a) If veteran, name war... None

3. (a) FULL NAME

MISS LINNIE ETTA GUESSFORD

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

None

7. Birth date of deceased (mo., day, yr.)

November 19 1888

6. (c) If alive, give age... years

8. AGE:

Years

Months

Days

If less than one day

58515

hrs.

min.

9. Birthplace... Hagerstown Washington Co., Md.
(Town, county, and state)10. Usual occupation... House work

11. Industry or business

Own Home

FATHER

12. Name

John M. Guessford

13. Birthplace

Williamsport Md.

MOTHER

14. Maiden name

Ida M. Boward

15. Birthplace

Hagerstown Md.

16. Informant

Mrs. Dolly Lehman

Address

Hagerstown Md.

17.

Burial

Date thereof

5/9/47

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Rose Hill Cemetery

Location

Hagerstown Md.

18. Funeral director

Andrew K. Coffman

Address

Hagerstown Md.

19.

May 8.

19.

47Charles Bowers

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... May 6, 19 47 at 10P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to 19...

and that I last saw him... alive on 19...

Immediate cause of death

DURATION

Chr. myocarditis

Due to

acute ventricular fibrillation

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results... no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... no Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

DEPUTY MEDICAL EXAM.

WASH. CO., MD.

M. D.

Address

Hagerstown, Md.

Date signed

5/7/47

MARGIN RESERVED FOR BINDING

VS A15 945-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 10 1947
BUREAU 78

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

48

04401

304

1. PLACE OF DEATH;

County WashingtonCity or town Hancock
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hancock
(If outside city or town limits, write RURAL and give nearest town)Street No. Main Street
(If rural, give LOCATION)2.(a) If veteran, name war World War I

3. (a) FULL NAME

George Whyte Gunnells

3. (b) Social Security Number

—4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Mabel Ritz Gunnells7. Birth date of deceased (mo., day, yr.) Dec. 20, 1898 6.(c) If alive, give age 40 years8. AGE: Years 48 Months 5 Days 3 If less than one day — hrs. — min.9. Birthplace Hancock, Washington, Md.
(Town, county, and state)10. Usual occupation Merchant

11. Industry or business

12. Name John Wesley Gunnells13. Birthplace Hancock, Md.14. Maiden name Margaret Ann Trimble15. Birthplace Hancock, Md.16. Informant Mrs. Mabel GunnellsAddress Hancock, Md.17. Burial Date thereof May 26, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Thomas EpiscopalLocation Hancock, Md.18. Funeral director Charles R. BastAddress Hancock, Md.19. 5/26-47 John Heller
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-23 1947 at 10:15 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

five 1944, to 5-23 1947and that I last saw him alive on 5-23 1947Immediate cause of death HemorrhageDue to FibrosarcomaDue to left thigh

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Herbert R. Rohias, M.D.Address Hancock, Md. Date signed 5-24-47

M. D. or other

RECEIVED

MAY 28 1947

BUREAU 7.2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Write correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-6)

CERTIFICATE OF DEATH

Dr. Conrad

04402
Reg. Dist. No. 302 305

1. PLACE OF DEATH:

County Washington
City or town Breathedsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 Years
Hospital, institution, or street address where death occurred:
Maryland State Reformatory for Males
How long in hospital or institution? 2 Years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 21 O'Brien Court
(If rural, give LOCATION)
2.(a) If veteran, name war None

3. (a) FULL NAME

JOHN WESLEY HEBRON

3. (b) Social Security Number

215-05-2473

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife ----

7. Birth date of deceased (mo., day, yr.) April 12, 1915
6. (c) If alive, give age ---- years

8. AGE: Years 32 Months 1 Days 18 It less than one day --- hrs. --- min.

9. Birthplace Annapolis Anne Arundel Co. Md.
(Town, county, and state)

10. Usual occupation Truck Driver

11. Industry or business

12. Name John W. Hebron Sr.
13. Birthplace Annapolis Md.

14. Maiden name Eleanor Watkins
15. Birthplace Annapolis Md.

16. Informant From Files Md. St. Ref.
Address Breathedsville Md.

17. Burial Date thereof June 3, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Annapolis Cemetery
Location Annapolis Md.

18. Funeral director Andrew R. Coffman
Address Hagerstown Md.

19. May 31, 1947 John H. Back
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30, 1947 at 1:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1, 1946 to May 30, 1947
and that I last saw him alive on May 29, 1947

Immediate cause of death Pulm. Tuberculosis
DURATION 8 yrs

Due to -----
Due to -----

Other conditions -----
(Include pregnancy within 3 months of death)

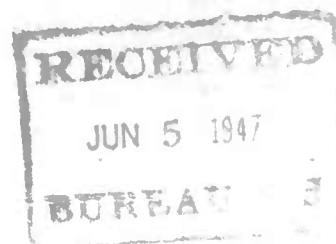
Major findings of operations -----
Date of op. -----

Autopsy results -----
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ----- Date of -----
Where did injury occur? ----- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -----
Means of injury ----- Injured at work? -----

23. SIGNATURE Robert P. Conrad, M.D.
M. D. or other -----
Address Hagerstown, Md. Date signed 5-31-47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Dr. Beachley

52

CERTIFICATE OF DEATH

Reg. Dist. No. 04403302

1. PLACE OF DEATH:

County... Washington
 City or town... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 Hours
 Hospital, institution, or street address where death occurred:
Broadfording Road
 How long in hospital or institution? --

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Maryland County... Washington
 City or town... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 25 Broadway Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war... None

3. (a) FULL NAME

JOSEPH HENRY HERSHEY

3. (b) Social Security Number

220-16-3459

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Crystal Hershey
 6. (c) If alive, give age 46 years
 7. Birth date of deceased (mo., day, yr.) August 15, 1900
 8. AGE: Years 46 Months 8 Days 21 If less than one day hrs. min.
 9. Birthplace Hagerstown, Washington Co., Md.
 (Town, county, and state)
 10. Usual occupation Guard
 11. Industry or business Fairchild Aircraft Corp.
 12. Name Barry O. Hershey
 13. Birthplace Hagerstown Md.
 14. Maiden name Julia Brunback
 15. Birthplace Winchester Va.

16. Informant Mrs. Crystal Hershey
 Address Hagerstown Md.
 17. Burial Burial Date thereof 5/8/47
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Dunkard Cemetery
 Location Broadfording Md.
 18. Funeral director Andrew K. Coffman
 Address Hagerstown Md.
 19. May 8, 47 Beachley Powers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

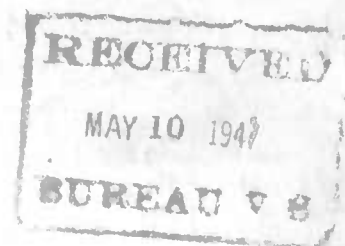
20. DATE OF DEATH May 6, 1947 at 11:30 AM
 21. I CERTIFY that death occurred on the date above stated; that I attended the deceased from May 4, 47 to May 6, 47
 and that I last saw him live on May 6, 1947
 Immediate cause of death Electrocution
 DURATION seconds
 Due to 182
 Due to Fracture of Skull
 (Include pregnancy within 3 months of death)
 Major findings of operations Sudden
 Date of op. 1947
 Autopsy results 193
 PHYSICIAN: Please underline the cause to which death should be charged statistically.
 22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Accident Date of May 6/47
 Where did injury occur? Fell from pole (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) 5/1/47
 Means of injury Injured at work?
 23. SIGNATURE Dr. Beachley M. D. or other May 6/47
 Address Hagerstown Date signed May 6/47

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 04404302

1. PLACE OF DEATH:

County..... Washington
Hagerstown
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....
1 hour
 Hospital, institution, or street address where death occurred:
44 N. Jonathan St.
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland County..... Baltimore
 City or town..... Ilchester
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... ✓

3. (a) FULL NAME

Lloyd D. Hess

3. (b) Social Security Number

4. Sex..... Male 5. Color or race..... White 6.(a) Single, married, widowed, or divorced..... Divorced
 6.(b) Name of husband or wife..... Flora Hess
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.)..... Nov. 9. 1886
 8. AGE: Years..... 60 Months..... 6 Days..... 4 It less than one day..... hrs. min.

9. Birthplace..... St. Louis Mo.
 (Town, county, and state)
 10. Usual occupation..... Engineer
 11. Industry or business..... Advertiser
 12. Name..... John Hess
 13. Birthplace..... St. Louis Mo.
 14. Maiden name..... D. Ella Dwyer
 15. Birthplace..... Cochocton Ohio.

16. Informant..... Mrs. Warren A. Tyrrell
 Address..... 5 Prospect Place N.Y. 17

17. Cremation Date thereof..... 5-17-47
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Buried or crematory..... W. S. Lee's Son
 Location..... Washington D. C.
 18. Funeral director..... Scott F. Minnich & Son
 Address..... Hagerstown Md.

19. May 16. 47 Registrar..... Charles H. Bowers
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 13 47 11:40 a. m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... 19..... to..... 19.....
 and that I last saw him..... alive on..... 19.....

Immediate cause of death.....
 DURATION.....
acute coronary occlusion
with infarction (left ventricle)
3 days probable
 Due to.....
acute ventricular fibrillation
 Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations.....
 Date of op.....
 Autopsy results..... as above May 13'47
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... No Date of.....
 Where did injury occur?.....
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?
 23. SIGNATURE..... Dr. R. H. Hells DEPUTY MEDICAL EXAM.
 Address..... Hagerstown, Md. WASH. CO., MD.
 Date signed..... May 14 '47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 19 1947

BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04405

Reg. Dist. No. 302

1. PLACE OF DEATH:

County WASHINGTON
City or town HAGERSTOWN
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 DAY
Hospital, institution, or street address where death occurred:
WASHINGTON COUNTY HOSPITAL
How long in hospital or institution? 1 DAY

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State PENNSYLVANIA County FRANKLIN
City or town SHADY GROVE
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war NON-VET

3. (a) FULL NAME

MABEL HOLLINGER

3. (b) Social Security Number

NONE

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced SINGLE

6. (b) Name of husband or wife _____

6. (c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) JUNE 3, 1886

8. AGE: Years 60 Months 11 Days 11 If less than one day _____ hrs. _____ min.

9. Birthplace SHADY GROVE, FRANKLIN, PENNA
(Town, county, and state)

10. Usual occupation HOUSE WIFE

11. Industry or business

12. Name SAMUEL HOLLINGER

13. Birthplace PENNSYLVANIA

14. Maiden name MARTHA BUSH

15. Birthplace PENNSYLVANIA

16. Informant Ethel Shank

Address Greencastle, Penna

17. BURIAL Date thereof MAY 17, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Apton Cemetery

Location Apton Penna

18. Funeral director W. J. Horment

Address Hagerstown Md.

19. May 14, 47 Registrar Chas. Bowers
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 14 MAY 1947 at 7:10 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from MARCH 1947 to MAY 14 1947
and that I last saw HER alive on MAY 13 1947

Immediate cause of death CONGESTIVE HEART FAILURE DURATION 1 DAY

Due to MUCLARDITIS

Due to _____

Other conditions ARTHRITIS HYPERTROPHIC 5-6 yrs
ULCERS DECURITUS MULTIFOCAL 5 MO
(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE W. D. Laemo, M.D. M. D. or other _____

Address 100 Professional Bldg Date signed May 14, 47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 16 1947

CHEROKEE

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Smithsburg and
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 10 Hours
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 10 Hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)
 State Maryland County Washington
 City or town Smithsburg and
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. none R. 702
 (If rural, give LOCATION)
 2.(a) If veteran, name war none

3. (a) FULL NAME

Mildred-Leona Huntberry

3. (b) Social Security Number

none

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Verdene Huntberry
 6.(c) If alive, give age 37 years
 7. Birth date of deceased (Mo., day, yr.) 8-26-1909
 8. AGE: Years 38 Months 17 Days 17 If less than one day hrs. min.

9. Birthplace Near Foxville, Fred Co and
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business Housekeeping
 12. Name Gra. Fox
 13. Birthplace Foxville, Fred Co and
 14. Maiden name Leany Wall
 15. Birthplace Near Foxville

16. Informant Verdene Huntberry
 Address Smithsburg and
 17. Burial Date thereof 5-16-1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematorium Smithsburg Cemetery
 Location Smithsburg and
 18. Funeral director Geo. B. Hoover
 Address Smithsburg, and
 19. May 14 19 47 Charles Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 19 47, at 80 M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 12 19 47 to May 13 19 47
 and that I last saw him alive on May 13 19 47

Immediate cause of death Pulmonary Emboli DURATION 2 hrs.
 Due to (Classical) Caesarian
section
 Due to Premature Separation 2 hrs
of placenta
 Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations premature separation
of placenta Date of op. May 12
 Autopsy results
 PHYSICIAN: Please underlie the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide. Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE E G Horder M. D. or other
 Address Smithsburg Date signed 5/14/47

RECEIVED

MAY 16 1947

BUREAU 18

Mildred Leona Huntberry

Residence should

Read Smithsburg. Md

R.F.D. #2

Chas. H. Bowers
Loc. Reg.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-8)

04406

CERTIFICATE OF DEATH

Reg. Dist. No. 307

1. PLACE OF DEATH:

County WashingtonCity or town Gaithersburg (Rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Gaithersburg
(If outside city or town limits, write RURAL and give nearest town)Street No. Return Washington and Gaithersburg
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

James Willis Jones

3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Dora V. Martin

6. (c) If alive, give age

69 years

7. Birth date of

deceased (mo., day, yr.)

Jan. 7 1869

8. AGE:

Years

78

Months

4

Days

19

If less than one day

hrs.

min.

9. Birthplace

Maryland
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Farm

12. Name

William F. Jones

13. Birthplace

Virginia

14. Maiden name

Rachel Pomeroy

15. Birthplace

Virginia

16. Informant

Blaise C. Jones

Address

Brownsville Md

17. (Burial, cremation, or removal) Which?

Burial

Date thereof

May 29 1947
(month) (day) (year)

Cemetery or crematory

Brithum

Location

Simplex Manor

18. Funeral director

W. H. Duff & Son

Address

Brownsville Md.

19. May 28

(Date rec'd by registrar)

19

47

Cornelius H. Gault

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26 1947 at 7 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 1 1947 to May 26 1947and that I last saw him alive on May 21 1947

Immediate cause of death

Cerebral Thrombosis

DURATION

8 weeks

Due to

Cerebral arteriosclerosis1 yr plus

Due to

General arteriosclerosis4 yrs plus

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underwrite the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Walter B. Shady, M.D.

M. D. or other

Address

Sharpsburg, Md

Date signed

5/28/47

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 4 1947

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. welty

04407

Reg. Dist. No. 302

1. PLACE OF DEATH:

County... Washington
 City or town... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 Years
 Hospital, institution, or street address where death occurred:
63 Broadway
 How long in hospital or institution? --

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Washington
 City or town... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 63 Broadway
 (If rural, give LOCATION)
 2.(a) If veteran, name war... None

3. (a) FULL NAME

HARRY E. KEEDY

3. (b) Social Security Number

216-23-9404

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Louise P.
 6.(c) If alive, give age 60 years
 7. Birth date of deceased (mo., day, yr.) July 18 1876
 8. AGE: Years 70 Months 9 Days 13 If less than one day
 hrs. min.

9. Birthplace Eakles Mill Wash. Co. Md
 (Town, county, and state)
 10. Usual occupation Furniture Dealer
 11. Industry or business Retired
 12. Name Josephus Keedy
 13. Birthplace Keedysville Md.
 14. Maiden name Martha Keefauver
 15. Birthplace Keedysville Md.

16. Informant Harry E. Keedy Jr.
 Address Hagerstown Md.
 17. Burial Date thereof 5/4/47
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Rose Hill Cemetery
 Location Hagerstown, Maryland
 18. Funeral director Andrew K. Coffman
 Address Hagerstown Md.
 19. May 3, 47 Shuff/Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1 1947 19 47 at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
November 19 46 to May 1 19 47
 and that I last saw him alive on May 1 19 47

Immediate cause of death Myocardial Infarction
 DURATION 4 days

Due to Myocardial Infarction - Coronary
Arteriosclerosis (Hypertension) DURATION 4 years

Other conditions
 (Include pregnancy within 3 months of death)

Major findings of operations
 Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Dalter M. Welty
 M. D. or other
 Address 998 Potomac Ave Date signed 5/2/47

RECEIVED

MAY 6 1947

BUREAU

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

04408

65

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 18 years
 Hospital, institution, or street address where death occurred:
24 1/2 Harmans Avenue
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 24 1/2 Harmans Avenue
 (If rural, give LOCATION)
 2.(a) if veteran, name war

3. (a) FULL NAME

William Lawson Keller

3. (b) Social Security Number
214-14-6490

4. Sex Male	5. Color or race White	6. (a) Single, married, widowed, or divorced Single
6. (b) Name of husband or wife		
7. Birth date of deceased (mo., day, yr.) Dec. 23, 1921		
8. AGE: Years 25,	Months 4	Days 19 If less than one day hrs. min.

6. (c) If alive, give age..... years

9. Birthplace Waynesboro, Franklin Co. Pa.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER	12. Name <u>Lawson Keller</u>
	13. Birthplace <u>Waynesboro, Penna.</u>
MOTHER	14. Maiden name <u>Pearl A. Shrader</u>
	15. Birthplace <u>Downsville, Maryland.</u>

16. Informant Mrs. Pearl A. Keller
 Address 24 1/2 Harmans Ave. Hagerstown, Md.

17. Burial Date thereof May 14, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Rose Hill Cemetery
 Location Hagerstown, Md.

18. Funeral director Fred W. Kraiss
 Address Hagerstown, Md.

19. May 15, 47 Charles Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 May 19 47 at 11:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
1 May 19 46 to 12 May 19 47
 and that I last saw him alive on 9 May 19 47

Immediate cause of death Pulmonary Tuberculosis
 DURATION 7 1/2 years

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE J. J. Lusk M. D. other
 Address 2301 P. Street Date signed 14 May 47

RECEIVED

MAY 17 1947

BUREAU V A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 3.01

I. PLACE OF DEATH:

County WashingtonCity or town Rural - Sharpsburg Md. Rt. 1
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 weeks

Hospital, institution, or street address where death occurred: _____

How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Pennsylvania County FultonCity or town Rural - Needmore Pa Rt. 1
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

NEWTON JASPER KNABLE

3. (b) Social Security Number

4. Sex

MALE

5. Color or race

White

6. (a) Single, married, widowed, or divorced

WIDOWED

6. (b) Name of husband or wife _____

7. Birth date of

deceased (mo., day, yr.) Aug 10. 1861

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

85910— hrs.— min.9. Birthplace MCCONNELLSTOWN - FULTON - PENN.
(Town, county, and state)10. Usual occupation FARMER

11. Industry or business _____

MOTHER FATHER

12. Name WILLIAM KNABLE13. Birthplace BIG COVE TANNERY PA.14. Maiden name MARGARET BIVINS15. Birthplace BIG COVE TANNERY PA.

16. Informant

Needmore Pa. (R.D. #1)17. BURIAL Date there MAY 23 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory EBENEZERLocation SIPES MILL PA.

18. Funeral director

W. Sipes
Address Harrisonville Pa19. May 22 1947
(Date rec'd by registrar)E. Le McElroy
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/20/47 19____ at 4P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4/22/47 19____ to 5/20/47 19____and that I last saw him alive on 5/20/47 19____

Immediate cause of death

Coronary Occlusion

DURATION

2 Days

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE

M. D. or other

Address Needmore Pa Date signed 5/21/47

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

MAY 27 1947

BUREAU V &

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

04410

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? life
 Hospital, institution, or street address where death occurred: Nursing Home
241 S. Prospect Street
 How long in hospital or institution? 2 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 256 S. Locust Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Ida V. Kridler

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow

6.(b) Name of husband or wife Harvey R. Kridler

7. Birth date of deceased (mo., day, yr.) Nov. 11, 1867 6.(c) If alive, give age..... years

8. AGE: Years 79 Months 5 Days 26 If less than one day..... hrs. min.

9. Birthplace Washington County, Md.
 (Town, county, and state)
 10. Usual occupation Home Duties

11. Industry or business

12. Name ----- Chapman13. Birthplace Unknown14. Maiden name Unknown15. Birthplace Unknown16. Informant Miss Lillian KridlerAddress 256 S. Locust St. Hagerstown, Md.

17. Burial Date thereof May 10, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill CemeteryLocation Hagerstown, Md.18. Funeral director Fred W. KraissAddress Hagerstown, Md.

19. May 10, 47 Chas H. Powers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8, 1947 12:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 - 47 19 to May 6 - 47 19
 and that I last saw alive on May 6 - 47 19

Immediate cause of death.....

DURATION

Due to Ch. Myocarditis 2 wks
6 yrs

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas H. Powers M. D.Address Hagerstown, Md. Date signed 5/10/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 13 1947

BUREAU V 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County..... Washington
 City or town..... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 80 years
 Hospital, institution, or street address where death occurred:
 31 1/2 E. Franklin St.
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland County..... Washington
 City or town..... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 31 1/2 E. Franklin St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Hallie K. Lambert

3. (b) Social Security Number

4. Sex Female	5. Color or race White	6. (a) Single, married, widowed, or divorced Widowed	
6. (b) Name of husband or wife..... George S. Lambert			
7. Birth date of deceased (mo., day, yr.) November 4, 1861			
8. AGE: Years 85	Months 5	Days 29	If less than one day hrs. min.
9. Birthplace..... Boonsboro Wash. Md. (Town, county, and state)			
10. Usual occupation..... None			
11. Industry or business..... None			
FATHER	12. Name..... Samuel Mc.Clure		
	13. Birthplace..... Unknown		
	14. Maiden name..... Sophia Barkman		
MOTHER	15. Birthplace..... Unknown		
	16. Informant..... Mr. E.D. Lambert Address..... Hagerstown Md.		
17. Burial Date thereof 5-5-47 (Burial, cremation, or removal. Which?) (month) (day) (year) Cemetery or crematory..... Rose Hill Cemetery Hagerstown Md. Location..... Scott F. Minnich & son Hagerstown Md.			
18. Funeral director..... Scott F. Minnich & son Address..... Hagerstown Md.			
19. May 5, 1947 Registrar (Date rec'd by registrar)			

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 3, 1947, at 2:30a. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19..... to 19..... and that I last saw ~~ER~~ alive on ~~1917~~ 19.....

Immediate cause of death..... chr. myocarditis

Due to..... acute ventricular fibrillation

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results..... No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... No Date of
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury..... Injured at work?

23. SIGNATURE..... S. Robert Wells DEPUTY MEDICAL EXAM.
 Address..... Hagerstown, Md. Date signed May 3/47

RECEIVED

MAY 7 1947

BUREAU 18

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 years

Hospital, institution, or street address where death occurred:

717 Summit Ave.How long in hospital or institution? at Home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 717 Summit Avenue
(If rural, give LOCATION)2. (a) If veteran, name war no.

3. (a) FULL NAME

Herbert Eugene Lovell

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Widowed6. (b) Name of husband or wife Anne E. Lovell7. Birth date of deceased (mo., day, yr.) March - 29 - 1866
6. (c) If alive, give age. years8. AGE: Years Months Days If less than one day
81 1 12 hrs. min.9. Birthplace Balghunston Wash. Co. Md.
(Town, county, and state)10. Usual occupation Retired Merchant

11. Industry or business

12. Name Dr. Albert S. Lovell13. Birthplace Pennsylvania14. Maiden name Susan M. Snavely15. Birthplace Mill Point Wash. Co. Md.16. Informant Mrs. Walter A. McCuneAddress 717 Summit Ave. Hagerstown Md.Burial Date thereof May 14, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Boonsboro MausoleumLocation Boonsboro Md.18. Funeral director Wm. J. Best & SonsAddress Boonsboro Md.19. May 12, 1947 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May - 11 - 1947 at 5:00 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov - 9 - 1946 to May 11 - 1947and that I last saw him alive on May 10 - 1947Immediate cause of death Chronic Myocarditis

DURATION

6 mos. 2 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

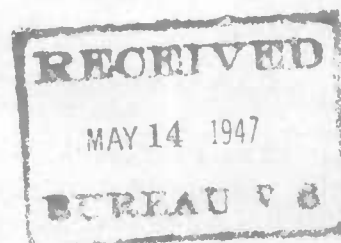
Means of injury Injured at work?

23. SIGNATURE Albert S. Lovell M. D. or otherAddress Boonsboro Md. Date signed 5/11/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92)

CERTIFICATE OF DEATH

Dr. Houghton

57

04413302
Reg. Dist. No.

1. PLACE OF DEATH:

County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 Weeks
Hospital, institution, or street address where death occurred:
Washington County Hospital
How long in hospital or institution? 2 Weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Washington
City or town Highfield
(If outside city or town limits, write RURAL and give nearest town)
Street No. ---
(If rural, give LOCATION)
2.(a) If veteran, name war None

3. (a) FULL NAME

ELLSWORTH McCREA

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
6.(b) Name of husband or wife Estella Mathews
6.(c) If alive, give age --- years
7. Birth date of deceased (mo., day, yr.) April 26, 1861
8. AGE: Years 86 Months 0 Days 13 If less than one day --- hrs. --- min.

9. Birthplace Ashland, Ashland Co., Ohio
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business Retired

12. Name No Record

13. Birthplace No Record

14. Maiden name No Record

15. Birthplace No Record

16. Informant Vawn E. McCrea

Address Highfield Md.

17. Burial Date thereof 5/12/47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory U. B. Cemetery

Location Thurmont Md.

18. Funeral director Andrew K. Coffman

Address Hagerstown Md.

19. May 10, 47 Registrar Shaft Bowers
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9, 1947 at 11:25 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 25, 1947 to May 9, 1947
and that I last saw him alive on May 9, 1947

Immediate cause of death chronic myocarditis
Senility
DURATION 2 yrs +

Due to ---

Due to ---

Other conditions Benign prostatic hypertrophy
(Include pregnancy within 3 months of death)

Major findings of operations No operation

Date of op. ---

Autopsy results ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide --- Date of ---

Where did injury occur? --- (City or town) --- (County) --- (State)

Injured at home, farm, industry, public place (where?) ---

Means of injury --- Injured at work? ---

23. SIGNATURE J. L. Houghton M.D.

Address Hagerstown Md Date signed May 10, 1947

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 13 1947

BUREAU V S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 15120

CERTIFICATE OF DEATH

Reg. Dist. No. 04414 302

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Washington County HospitalHow long in hospital or institution? ONE DAY

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County WashingtonCity or town Big Springs
(If outside city or town limits write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

CAROLYN JOYCE MELLOTT

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

8. (c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.)

MAY 20, 1946

8. AGE:

Years

Months

Days

If less than one day

ONESEVEN

hrs.

min.

9. Birthplace Washington County
(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER

FATHER

12. Name Philibart L. Mellott13. Birthplace Washington County14. Maiden name Crystal C. Bartles15. Birthplace Washington County16. Informant Philibart L. MellottAddress Big Springs, Maryland17. BURIAL Date thereof MAY 29, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Pauls CemeteryLocation NEAR Clearspring, Maryland18. Funeral director Mrs. Albert LeasAddress Williamsport, Maryland19. MAY 28, 1947 Registrar David P. Brewer
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27, 1947 at 10 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 20, 1947 to May 27, 1947 and that I last saw her alive on May 27, 1947

Immediate cause of death

Broncho Pneumonia
Cardiac Hypertrophy
Congenital

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Manner of injury

Injured at work?

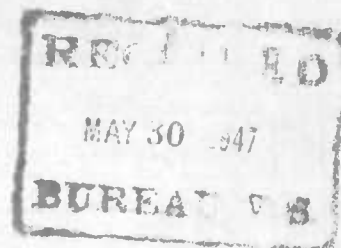
23. SIGNATURE

David P. Brewer M.D.
Clear Spring Md. Date signed 5/28/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County..... Washington
 City or town..... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 1 week

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Maryland County..... Washington
 City or town..... Rural Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... Hagerstown R. R. #4
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

George Alfred Miller

3. (b) Social Security Number

213-16-0920

4. Sex..... M 5. Color or race..... W 6.(a) Single, married, widowed, or divorced..... Married
 6.(b) Name of husband or wife..... Mary E. (Statler)
 6.(c) If alive, give age..... 58 years
 7. Birth date of deceased (mo., day, yr.)..... January 1, 1875
 8. AGE: Years..... 72 Months..... 4 Days..... 13 If less than one day..... hrs. min.

9. Birthplace..... Mercersburg, Franklin Co., Pa.
 (Town, county, and state)
 10. Usual occupation..... Cabinet Maker
 11. Industry or business..... Furniture Factory
 12. Name..... George Miller
 13. Birthplace..... No Record
 14. Maiden name..... Elizabeth Clever
 15. Birthplace..... No Record

16. Informant..... Mrs. Mary E. Miller
 Address..... Hagerstown R.R.#4

17. Burial..... May 17, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... Church of the Brethren Cem.
 Location..... Upton, Penna.

18. Funeral director..... Jacob A. Teeter
 Address..... Greencastle, Penna.

19. May 16, 47
 (Date rec'd by registrar) Registrar..... Robert H. Bowers

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 14 1947, at 5:20 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
May 11 1947, to May 14 1947
 and that I last saw h. l. m. alive on May 14 1947
 Immediate cause of death..... Cardiac Failure

DURATION
2 yr
3 yr?
 Due to..... Myocardial Insufficiency
Arteriosclerosis
 Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations.....
 Date of op.....
 Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

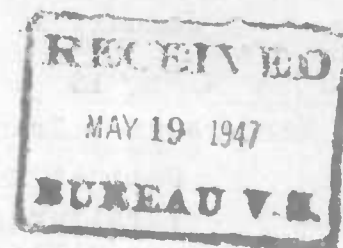
22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE..... Robert Vh Campbell MD
 Address..... Hagerstown Md Date signed..... May 16/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No.

04416

303

1. PLACE OF DEATH:

County Washington
City or town (If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 8 weeks.

Hospital, institution, or street address where death occurred:

Gale Way Nursing HomeHow long in hospital or institution? 8 weeks.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Marysville
(If outside city or town limits, write RURAL and give nearest town)Street No. main st.

(If rural, give LOCATION)

2. (a) If veteran, name war no.

3. (a) FULL NAME

Charles Henry Minnelaker

3. (b) Social Security Number

none.

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Widowed6. (b) Name of husband or wife Rhoda King Minnelaker6. (c) If alive, give age years7. Birth date of deceased (mo., day, yr.) July - 21 - 18708. AGE: Years Months Days If less than one day
76 9 15 hrs. min.9. Birthplace near Centres Wash. Co. Md.
(Town, county, and state)10. Usual occupation Owner and Operator of11. Industry or business newspaper - (Retired)12. Name John H. Minnelaker13. Birthplace Wash. Co. Md.14. Maiden name Elizabeth Gordon15. Birthplace near Greencastle Penna.16. Informant Mrs. Joseph StineAddress Marysville Md.17. Burial - Date thereof May 9, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Boonsboro CemeteryLocation Boonsboro Md.18. Funeral director Chas. J. Best & SonsAddress Boonsboro Md.19. May 8th 1947 Lois M. Keller
(Date registered by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May - 1947 at 11:55 P.M.21. CERTIFY that death occurred on the date above stated; that I attended deceased from December 3, 1943 to May 6, 1947and that I last saw him alive on May 6, 1947Immediate cause of death HypertensiveCardio-vascular diseaseDue to Due to Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op. Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of Where did injury occur? (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Means of injury Injured at work? 23. SIGNATURE Lidney Noventzen M.D.Address 2urbastown Md. Date signed 5/7/47

M. D. or other

Address 2urbastown Md. Date signed 5/7/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Noventzen

RECEIVED

JUN 10 1947

BUREAU V B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. LeVan

04417

Reg. Dist. No. 305

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown R # 3
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 10 YearsHospital, institution, or street address where death occurred:
RoxburyHow long in hospital or institution? --

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown R # 3
(If outside city or town limits, write RURAL and give nearest town)Street No. Roxbury
(If rural, give LOCATION)2.(a) If veteran, name War None

3. (a) FULL NAME

Mrs. Mary salome Spalding Mitchell4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Joseph E.6.(c) If alive, give age 60 years7. Birth date of deceased (mo., day, yr.) December 25 18908. AGE: Years 56 Months 4 Days 10 hrs. min.9. Birthplace Point of Rocks Fred. Co. Md.
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Own Home12. Name Howard Spalding13. Birthplace Frederick Md.14. Maiden name Hattie Nichols15. Birthplace Frederick Md.16. Informant Joseph E. MitchellAddress Hagerstown Md. R # 317. Burial Date thereof 5/8/47
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rest Haven CemeteryLocation Hagerstown Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. May 7. 19 47 John H. Bait
(Date rec'd by registrar) Registrar

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5 1947 19 47 at 2.30 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 5 19 47 to May 5 19 47 and that I last saw him alive on May 5 19 47Immediate cause of death Hypertensive cardiac vascular disease
Cerebral HemorrhageDue to Cerebral Hemorrhage

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. LeVan M. W. M. D. orAddress Brownsville Date signed 5/7/47

RECEIVED

MAY 12 1947

BUREAU 88

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

04418 49

CERTIFICATE OF DEATH

Reg. Dist. No. 3022

1. PLACE OF DEATH:

County Washington
 City or town Harper's Ferry, Md.
 Street address, hospital, or institution Washington County Hospital
 Stay in hospital or inst. (yrs., or mos., or days) 1 day
 Stay in this community (yrs., or mos., or days) _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md. County Washington
 City or town Harper's Ferry, Md. Ward No. _____
 (If outside city or town limits, write RURAL NEAR and give town)
 (If rural give LOCATION)
 2(a) IF VETERAN, NAME WAR _____

3. (a) FULL NAME

Thelma Jean Mitchell

3. (b) Social Security Number

4. Sex Female 5. Color or race W. & S. 6. (a) Single, married, widowed, or divorced _____

(b) Name of husband or wife _____

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) May 7, 1947

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Washington, Washington, Md.
 (Town, county, and state)

10. Usual occupation None

11. Industry or business _____

12. Name Cather Mages

13. Birthplace Washington County, Md.

14. Maiden name Frances Waters

15. Birthplace Washington County, Md.

16. Informant Frances Mitchell

Address Harper's Ferry, Md. R# 1

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 7, 1947
 (month) (day) (year)

Cemetery or crematory Samples Manor

Location Harper's Ferry R. F. D. # 1

18. Funeral director R. I. Earnshaw

Address Keedysville, Md.

19. May 8, 1947 Registrar W. H. Bowers

(Date recd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 1947, at _____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ to _____ 1947

and that I last saw him alive on May 7 1947

Immediate cause of death _____ DURATION _____

Prematurity

Due to _____

Cause unknown

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings: _____

Of operations None

Of autopsy _____

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

23. SIGNATURE Walter H. Shady M. D. or other _____

Address Sharpsburg, Md. Date signed 5/7/47

PHYSICIAN

Please underline the cause to which death should be charged statistically.

RECEIVED

MAY 10 1947

BUREAU 78

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

50

04419

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County WashingtonCity or town Smithsburg Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Wash Co HospitalHow long in hospital or institution? 2 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Smithsburg Md
(If outside city or town limits, write RURAL and give nearest town)Street No. none
(If rural, give LOCATION)2.(d) If veteran, name war none

3. (a) FULL NAME

Etta Marie Monath

3. (b) Social Security Number

none4. Sex Female5. Color or race White6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife none7. Birth date of deceased (Mo., day, yr.) 8-28-1891

6. (c) If alive, give age _____ years

8. AGE: Years 55 Months 9 Days 23 It less than one day _____ hrs. _____ min.9. Birthplace Westminster Md
(Town, county, and state)10. Usual occupation Housekeeping11. Industry or business housekeeping12. Name Dout. Knowl.13. Birthplace ...14. Maiden name Marie Beaver15. Birthplace Westminster Md16. Informant Earl MonathAddress Smithsburg Md R. F. D.17. Burial Date thereof 5-24-1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory SmithsburgLocation Smithsburg Md18. Funeral director Geo. B. HooverAddress Smithsburg Md19. May 22, 1947 Registrar Health Board
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21 19 47 at 3:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 15 19 45 to May 21 19 47and that I last saw h. 21 alive on May 21 19 47

Immediate cause of death _____ DURATION _____

Cancer of breast 2 yrsCancer of cervix uteri 18 mos.Cancer of liver 2 mospancreasOther conditions Stroke followingsystemic capillary

(Include pregnancy within 3 months of death)

Major findings of operations see aboveDate of op. Exp. CapAutopsy results 5-20-47

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

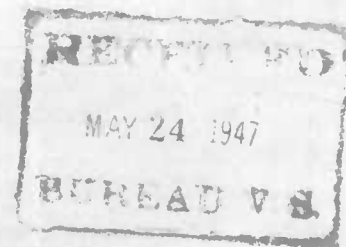
Means of injury _____ Injured at work? _____

23. SIGNATURE George Hoover M. D. or other _____Address Smithsburg Md Date signed 5/22/47

MARGIN RESERVED FOR BINDING

VS A15A 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04420

Reg. Dist. No. 306

1. PLACE OF DEATH:

County Washington
City or town Cascade
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Washington
City or town Cascade
(If outside city or town limits, write RURAL and give nearest town)
Street No. Cascade
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Mary Jane Moore

3. (b) Social Security Number

4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced widowed
6.(b) Name of husband or wife John Marshall Moore
6.(c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) Dec. 4, 1961
8. AGE: Years 85 Months 5 Days 7 It less than one day _____ hrs. _____ min.

9. Birthplace Cascade Md.
(Town, county, and state)

10. Usual occupation House wife

11. Industry or business

FATHER 12. Name Samuel Royce
13. Birthplace Franklin Co. Pa.

MOTHER 14. Maiden name Mary Jane Hammaker
15. Birthplace Franklin Co. Pa.

16. Informant Walter R. Moore
Address Cascade

17. Burial Date thereof 5/13/47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Bethel
Location Washington Co. Md.

18. Funeral director Walter R. Moore

Address 278 Church St. Waynesboro

19. May 13 19 47 Geo. W. Ferguson
(Date rec'd by registrar) (local) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10 19 47 at _____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-10 19 47 to 5-10 19 47 and that I last saw him alive on 5-10 19 47

Immediate cause of death _____ DURATION _____

Carcinoma

Due to Stomach & Stomach

Other conditions Stomach

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

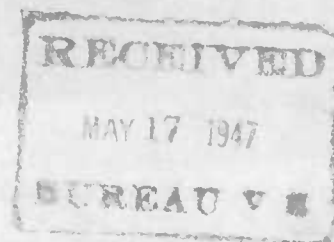
23. SIGNATURE H. B. Richards

Blue Ridge _____ M. D. or other _____
Address _____ Date signed 5/13/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

146C

04189

CERTIFICATE OF DEATH

Reg. Diat. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
Washington County Hospital
2 days
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 417 West Antietam Street
 (If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Helen M. Mowen

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Galen W. Mowen
 6. (c) If alive, give age 23 years
 7. Birth date of deceased (mo., day, yr.) October 31, 1915
 8. AGE: Years 31 Months 7 Days 12 If less than one day _____ hrs. _____ min.

9. Birthplace Hagerstown, Wash. Co. Md.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER
 12. Name Samuel Shoemaker
 13. Birthplace Millstone, Maryland
 14. Maiden name Margaret B. Diffendafer
 15. Birthplace Hagerstown, Maryland

16. Informant Galen W. Mowen
 Address Hagerstown, Maryland

17. Burial 5-22-47
 (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery
 Location Hagerstown, Maryland

18. Funeral director C. M. Suter & Sons
 Address Hagerstown, Maryland

19. May 22, 1947
 (Date rec'd by registrar) Registrar Christ H. Bowers

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19 19 47 at 4:35 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 18 19 47 to May 19 19 47
 and that I last saw him alive on May 19 19 47

Immediate cause of death Reaction to blood transfusions

Due to

Due to

Other conditions 2 weeks post partum - retained placental tissue
 (Include pregnancy within 3 months of death)

Major findings of operations Retained placenta
 Date of op. 5/18/47

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

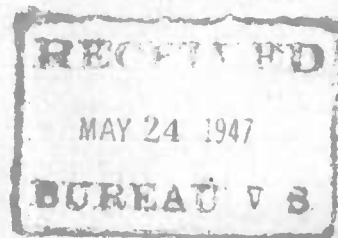
23. SIGNATURE Arthur Baptista, M.D.
 Address 2147 Potomac Highway Date signed 5/20/47

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 04421 307

1. PLACE OF DEATH:

County WashingtonCity or town Sandy Hook
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 80 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Sandy Hook
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Charlotte Louise Nuice

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widow6. (b) Name of husband or wife John H. Nuice7. Birth date of deceased (mo., day, yr.) October 9, 1863
6. (c) If alive, give age. -- years8. AGE: Years 83 Months 6 Days 27 It less than one day _____ hrs. _____ min.9. Birthplace Washington County, Maryland
(Town, county, and state)10. Usual occupation Housework11. Industry or business Own Home12. Name John Norris13. Birthplace Virginia14. Maiden name Aleinda Heskitt15. Birthplace Virginia16. Informant Mr. Landon E. NuiceAddress R.F.D. Knoxville, Maryland17. Burial Burial Date thereof 5/8/47
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Virts CemeteryLocation Sandy Hook, Maryland18. Funeral director William T. StinderAddress Charles Town, West Va.19. May 6 19 47 Cornelia H. Gasser
(Date rec'd by registrar) Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6, 19 47 at 11:40 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19 _____ to _____ 19 _____

and that I last saw him _____ alive _____ 19 _____

Immediate cause of death Stroke DURATIONJohn H. NuiceShe was somentally depressedshe would not letme examine herOther conditions 5-6-1947

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE S. Oscar Fry WestCharles TownJefferson County 5-6-1947 M. D. or otherAddress West Virginia Date signed _____

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 10 1947

BUREAU V S

Birth and Death

04422

MARYLAND STATE DEPARTMENT OF HEALTH 159
CERTIFICATE OF STILLBIRTH

Reg. Dist. No. 302

A certificate must be filed within 24 hours for every stillbirth of 20 weeks' gestation or more (see stub)

1. PLACE OF BIRTH:

County WashingtonCity or town Washington

(If outside city or town limits, write RURAL and give nearest town)

Street address, hospital, or institution:

Washington County HospitalLength of mother's stay in County 16 days

(How many years, or months or days. SPECIFY WHICH)

2. USUAL RESIDENCE OF MOTHER:

State MarylandCounty WashingtonCity or town Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1106 Virginia Ave.

(If RURAL give LOCATION)

3. Name of child Paul Eugene OsborneDate of birth May 1 19 47 Hour 11:27 A. M.5. Sex Male

6. Twin or triplet

7. No. of weeks pregnancy 7 mos

FATHER OF CHILD

8. Full name Paul Eugene Osborne9. Color W 10. Age at time of this birth 3 yrs.11. Usual occupation Household Service

MOTHER OF CHILD

12. Full maiden name Mary Gwendolyn Hays13. Color W 14. Age at time of this birth 20 yrs.15. Usual occupation Housewife16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 1(b) How many other children were born alive but are now dead? 0 (c) How many other children were born dead? 017. Did child die before labor? no During labor? no18. Pregnancy, complications of no19. Labor: (a) Complications of Prematurefontaine 52 wks. (b) Induced? no20. (a) Was there an operation for delivery? no(b) State all operations, if any. no (Yes or No)(c) Did child die before operation? noDuring operation? no

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.

(a) Fetal causes Prematurity (3)

(b) Maternal causes

22. I certify to the birth of this child who was born dead* on the date and hour above stated.

Signature Curtis Baptiste

(Specify if M. D. or wife or other)

Address 214 N. Potomac St. Washington, D.C.25. (a) May 5, 1947 (b) G. H. Bowers

(Date rec'd by registrar)

(Registrar)

26. (To be filled out if no physician was present at delivery.) The above certificate has been examined by me.

Health Officer, per

* See Instruction C on stub.

Child lived 22 hours
 28 min
 T
 24 as B o B
 V. S. A10

RECEIVED

MAY 7 1947

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr Sheeley, 04423
300

Reg. Dist. No.

1. PLACE OF DEATH:

County Washington
 City or town Sharpsburg
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 13 years
 Hospital, institution, or street address where death occurred:
Main St
 How long in hospital or institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Sharpsburg
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Main St
 (If rural, give LOCATION)
 2.(a) If veteran, name war none

3. (a) FULL NAME

MRS Elizabeth Middlekauff Peter

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife

A. Dolphus

7. Birth date of deceased (mo., day, yr.)

December 12-1860

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

86

4

21

hrs.

min.

9. Birthplace

BEAVER CREEK, WASH CO, MD
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Own home

FATHER

12. Name

Joseph M. Middlekauff

13. Birthplace

BEAVER CREEK MD

MOTHER

14. Maiden name

Annie Horine

15. Birthplace

BEAVER CREEK MD

16. Informant

Mrs J. Edgar Remsburg

Address

Sharpsburg MD

17.

Burial
(Burial, cremation, or removal. Which?)

Date thereof

6/2/47
(month) (day) (year)

Cemetery or crematory

Rest Haven Cemetery

Location

Hagerstown MD

18. Funeral director

ANDREW K. COFFMAN

Address

Hagerstown MD

19.

6/30
(Date rec'd by registrar)

19

47

E. J. Rogers
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

MAY 30

19

47, at 6 30 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 about 1936 to May 30 1947
 and that I last saw him alive on May 29 1947

Immediate cause of death

Coronary Vascular-Renal
Disease

DURATION

15 min.

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Walter H. Sheeley M.D.
Sharpsburg, Md.

M. D. or other

Date signed 5/30/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 17 1947

FBI WASH DC

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 304

1. PLACE OF DEATH:

County... Washington

City or town... Pectonville, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Washington

City or town... Pectonville
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

George Albert Reed

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife... Amanda L. Reed

8. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 6, 1881

8. AGE: Years Months Days If less than one day
65 8 7 hrs. min.9. Birthplace... Pectonville, (Wash. Co.) Md.
(Town, county, and state)

10. Usual occupation... Farmer

11. Industry or business

12. Name... John Reed

13. Birthplace... Pectonville, Md.

14. Maiden name... Lucy Dickerhoff

15. Birthplace... Pectonville, Md.

16. Informant... Amanda L. Reed

Address... Pectonville, Md.

17. Burial Date thereof... May 16-47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Cemetery Park Head

Location... Route 40 near Clear Spring

18. Funeral director... Snyder-Rowland

Address... Hancock, Md.

19. 548-47 J. H. Heller

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... May 13, 1947, at 6:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 12, 1947, to May 13, 1947, and that I last saw him alive on May 12, 1947.

Immediate cause of death... Chronic Carcinoma DURATION

Due to... Chronic myocardiitis

Due to...

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op.

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... M. D. or other

Address... Hancock, Md. Date signed... 5/13/47

RECEIVED

MAY 17 1947

BUREAU C S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No.

93d

04425

307

1. PLACE OF DEATH:

County WashingtonCity or town near Rohersville Rural
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

Rohersville Md.How long in hospital or institution? At home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Rohersville Rural
(If outside city or town limits, write RURAL and give nearest town)Street No. Rohersville Md.
(If rural, give LOCATION)2.(a) If veteran, name war no.

3. (a) FULL NAME

Jamie C. Rohrer

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife.

Single

7. Birth date of deceased (mo., day, yr.)

March 11, 1862

6. (c) If alive, give age. years

8. AGE:

Years

Months

Days

If less than one day

85121

hrs.

min.

9. Birthplace near Rohersville
(Town, county, and state)

10. Usual occupation

Housekeeper

11. Industry or business

Own home

FATHER

12. Name

Abraham Rohrer

13. Birthplace

near Rohersville Wash. Co. Md.

14. Maiden name

Mary Eseltmasher

MOTHER

15. Birthplace

near Rohersville Wash. Co. Md.

16. Informant

Leroy J. Rohrer

Address

Rohersville Md.

17.

(Burial, cremation, or removal, Which?)

Date thereof

May - 5 - 1947
(month) (day) (year)

Cemetery or crematory

Rohersville Cemetery

Location

Rohersville Md.

18. Funeral director

Wm J. Best & Sons

Address

Boulevard Md.

19.

(Date rec'd by registrar)

19. 47Mrs Katherine Daguehart

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May - 2 - 1947 at 1:40 PM M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 30 - 1947 to May 2 - 1947and that I last saw him alive on April 27 - 1947

Immediate cause of death

Chronic myocarditis

DURATION

1 hour 2 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Robert Wade M.D.

M. D. or other

Address

Rohersville Md.Date signed 5/3/47

MARGIN RESERVED FOR BINDING

VS-A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 10 1947

BUREAU 8

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH: Washington
 County: Hagerstown
 City or town: (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 29 years
 Hospital, institution, or street address where death occurred:
 Washington County Hospital
 How long in hospital or institution? 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State: Maryland County: Washington
 City or town: Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 821 Mulberry Ave.
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Minnie E. Rossman

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Harry M. Rossman
 6. (c) If alive, give age 74 years
 7. Birth date of deceased (mo., day, yr.) April 19, 1874
 8. AGE: Years 73 Months 1 Days 2 If less than one day hrs. min.

9. Birthplace Chambersburg Franklin Pa.
 (Town, county, and state)
 10. Usual occupation None
 11. Industry or business None
 12. Name Frank C. Lantz
 13. Birthplace Chambersburg Pa.
 14. Maiden name Martha Hauptman
 15. Birthplace Chambersburg Pa.

16. Informant Harry M. Rossman
 Address Hagerstown Md.

17. Burial Date thereof 5-23-47
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Cedar Grove Cemetery
 Location Chambersburg Pa.

18. Funeral director Scott F. Minnich & Son
 Address Hagerstown Md.

19. May 23, 47 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

2D. DATE OF DEATH May 21 1947 at 7:40p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/6/47 to 5/21/47

and that I last saw him alive on 5/21/47

Immediate cause of death Cerebral hemorrhage DURATION

Due to Hypertension

Due to Arteriosclerosis

Other conditions Ovarian cyst with adenocarcinoma of cyst wall
 (Include pregnancy within 8 months of death)

Major findings of operations Ovarian cyst left side Date of op. 5/8/47

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE R. H. Minnich Date signed 5/22/47

Address 170 V. Wash. Hagerstown Md.

RECEIVED

MAY 26 1947

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

99d

04427

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 years

Hospital, institution, or street address where death occurred:

131 King Street
at Home

3. (a) FULL NAME

Hallie Irene Routzahn

3. (b) Social Security Number

none

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Elmer F. Routzahn

7. Birth date of deceased (mo., day, yr.)

January - 8 - 1893

6. (c) If alive, give age

54 years

8. AGE: Years Months Days

54 3 24

9. Birthplace

Boonsboro Wash. Co. Md.

10. Usual occupation

Housewife

11. Industry or business

Own Home

12. Name

Thomas A. Snively

13. Birthplace

Boonsboro Wash. Co. Md.

14. Maiden name

Rose K. Esant

15. Birthplace

Boonsboro Wash. Co. Md.

16. Informant

Elmer F. Routzahn

Address

131 King St. Hagerstown Md.

17. Burial

May 6 1947

(Burial, cremation, or removal. Which?)

Boonsboro Cemetery

Boonsboro Md.

Location

Elmer F. Routzahn

18. Funeral director

Boonsboro Md.

Address

May 5 47

19. (Date rec'd by registrar)

148 W. Wash St. Hagerstown Md.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 131 King St.

(If rural, give LOCATION)

2. (a) If veteran, name war

no.

MEDICAL CERTIFICATION

20. DATE OF DEATH

May - 2 - 1947

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 20 1947 to May 2 1947

and that I last saw him alive on

Apr 30 1947

Immediate cause of death

Cerebral Hemorrhage

Due to

Cerebral Arteriosclerosis

with Vascular Hypertension

Due to

Arteriosclerotic Heart

Other conditions

Pneumonia

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

B. B. Kneisley M.D.

Address

148 W. Wash St. Hagerstown Md.

Date signed

5/3/47

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Kneisley

7
RECEIVED

MAY 7 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1702

04428

CERTIFICATE OF DEATH

Reg. Dist. No. 303

1. PLACE OF DEATH:

County Washington
 City or town Big Spring
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Big Spring Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Rural Clear Spring, Md.
 (If outside city or town limits, write RURAL and give nearest town)

Street No. Conococheague
 (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Harold James Ruback

3.(b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) July 17, 1943 B.(c) If alive, give age _____ years

8. AGE: Years 3 Months 10 Days 1 If less than one day _____ hrs. _____ min.

9. Birthplace Clear Spring, Wash. Co., Md.
 (Town, county, and state)

10. Usual occupation None

11. Industry or business

12. Name James F. Ruback13. Birthplace Clear Spring, Md.14. Maiden name Minnie Wiles15. Birthplace Clear Spring, Md.16. Informant James F. RubackAddress Clear Spring, Md. R D 1

17. Burial Date thereof May 21, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Paul's CemeteryLocation Near Clear Spring, Md. Route 4018. Funeral director Snyder-Rowland Funeral HomeAddress Clear Spring, Md.

19. May 21 1947 Joseph Mynar
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18, 1947 19 _____ at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19 _____ to _____ 19 _____

and that I last saw him _____ alive on _____ 19 _____

Immediate cause of death

Fractured skull (closed) 15min

Due to

Closed fracture of boneDue to about rt knee jointshock

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. _____

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 5/18/47Where did injury occur? Highway (City or town) Wash. Co. (County) Md. (State)Injured at home, farm, industry, public place (where?) Highway Route 40Means of injury Struck by auto Injured at work? No23. SIGNATURE S. R. Wiles DEPUTY MEDICAL EXAM.Address Highway, Md. WASH. CO., MD, M. D. _____Date signed 5/19/47

RECEIVED
MAY 26 1947
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 304

1. PLACE OF DEATH:

County Washington
 City or town Hancock, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hancock
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Pleasant Johnson Myers Sagle

3. (b) Social Security Number

4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced widowed

6.(b) Name of husband or wife Aaron Sagle

7. Birth date of deceased (mo., day, yr.) August 8, 1867 8.(c) If alive, give age _____ years

8. AGE: Years 79 Months 8 Days 25 If less than one day _____ hrs. _____ min.

9. Birthplace Hancock, Maryland
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Adam Myers13. Birthplace UNKNOWN14. Maiden name Harriet Myers15. Birthplace Unknown16. Informant Mrs Rosalie RankinAddress Hancock, Maryland

17. Burial Date thereof May 6, 1947
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory CemeteryLocation Hancock18. Funeral director Snyder-RowlandAddress Hancock, Maryland

19. 5-5-47 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-3 1947 at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-15 1946 to 5-3 1947 and that I last saw him alive on 4-28 1947

Immediate cause of death Angina PectorisDue to Arteriosclerotic Heart Disease

Due to

Other conditions Cerebral Hemorrhage

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Hubert R. Zofman, M.D.Address Hancock, Md Date signed 5-5-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 7 1947

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Di 04430

Reg. Dist. No. 302 305

1. PLACE OF DEATH:

County... WashingtonCity or town... Fairplay
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 33 Years

Hospital, institution, or street address where death occurred:

Spring Grove RoadHow long in hospital or institution? ---

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... WashingtonCity or town... Fairplay
(If outside city or town limits, write RURAL and give nearest town)Street No. Spring Grove Road
(If rural, give LOCATION)2.(a) If veteran, name war... None

3. (a) FULL NAME

OTHO FRANCIS SHOWMAN

3. (b) Social Security Number

None

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male White Married6.(b) Name of husband or wife... Harriet Boyer Showman6.(c) If alive, give age... 70 years7. Birth date of deceased (mo., day, yr.) April 4, 18768. AGE: Years Months Days If less than one day
71 1 4 --- hrs. --- min.9. Birthplace... Keedysville, Washington Co., Md.
(Town, county, and state)10. Usual occupation... Merchant11. Industry or business... Market12. Name... Adam Showman13. Birthplace... Fairplay Md.14. Maiden name... Mary Ellen Banks15. Birthplace... Fairplay Md.16. Informant... Mrs. Harriett ShowmanAddress... Fairplay Md.17. Burial Date thereof... 5/11/47
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory... Green Lawn CemeteryLocation... Williamsport Md.18. Funeral director... Andrew K. CoffmanAddress... Hagerstown Md19. May 10 1947 John H. Bax
(Date read by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... May 8, 19 47 at 3:30 A

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

May 31-47 19... to May 8-47 19and that I last saw him alive on May 7-47 19

Immediate cause of death

Coronary Disease

Due to

Ch. Myocarditis -Due to atherosclerosis

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

M. D. or other

Address Hagerstown Md Date signed 5/11/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully; the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 13 1947

BUREAU V A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully and correctly. Age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 50 years
 Hospital, institution, or street address where death occurred:
302 North Potomac Street
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 302 North Potomac Street
 (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Sallie Shulenberger

3.(b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow

6.(b) Name of husband or wife William C. Shulenberger

7. Birth date of deceased (mo., day, yr.) May 9, 1852 6.(c) If alive, give age _____ years

8. AGE: Years 95 Months 0 Days 1 If less than one day _____ hrs. _____ min.

9. Birthplace Martinsburg, W. Va.
 (Town, county, and state)

10. Usual occupation Housework

11. Industry or business

12. Name S. H. Martin
 13. Birthplace Bedford, Pa.

14. Maiden name Rachael Bowers
 15. Birthplace Bunker Hill, W. Va.

16. Informant Miss Eva Shulenberger
 Address Hagerstown, Maryland

17. Burial Date thereof 5-13-47
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery
 Location Hagerstown, Maryland

18. Funeral director C. M. Suter & Sons
 Address Hagerstown, Maryland

19. May 13, 1947 Rachael Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10 19 47, at 5:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 3 19 47, to May 10 19 47, and that I last saw him alive on May 10 19 47.

Immediate cause of death

myocardial Failure
arterio sclerotic
Heart disease

Due to arterio sclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ injured at work?

23. SIGNATURE

O. H. Binkley, M.D.
 Address Hagerstown, Md. Date signed 5/12/47

04431

93d

RECEIVED
MAY 15 1947
BUREAU OF

Evidence for the change of
birth date and age is
shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

926

04432

60

FILM No. G 110 MAY 21 1947

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County..... Washington
City or town..... Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?.....
Hospital, institution, or street address where death occurred:
Washington County Home
How long in hospital or institution?..... 3 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State..... Md. County..... Wash.
City or town..... Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME

John W. Sisk

3. (b) Social Security Number

4. Sex..... male
5. Color or race..... white
6. (a) Single, married, widowed, or divorced..... widowed

6. (b) Name of husband or wife..... Estella Sisk

7. Birth date of deceased (mo., day, yr.)..... Feb. 19 1/11/1867
6. (c) If alive, give age..... years

8. AGE: Years..... 80 Months..... 10 Days..... 10
If less than one day..... hrs. min.

9. Birthplace..... near Charlestown, Jeff. Co. W. Va.
(Town, county, and state)

10. Usual occupation..... none

11. Industry or business..... II

12. Name..... unknown

13. Birthplace..... II

14. Maiden name..... unknown

15. Birthplace..... II

16. Informant..... Daniel Sisk

Address..... Hagerstown, Md.

17. (Burial, cremation, or removal. Which?)..... burial

Date thereof..... 5-13-47
(month) (day) (year)

Cemetery or crematory..... Rose Hill Cemetery

Location..... Hagerstown, Md.

18. Funeral director..... Scott F. Minnich & Son

Address..... Hagerstown, Md.

19. (Date rec'd by registrar)..... May 13, 47

Registrar..... Ernest F. Pooler

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 11 1947 at 12:45p

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
May 1st 1947 to May 11 1947

and that I last saw him alive on May 10th 1947

Immediate cause of death.....

Due to..... Mitral Stenosis

Due to..... Acute congestive myocardial decompensation

Other conditions..... 9301

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... Ernest F. Pooler

Address..... Hagerstown, Md.

Date signed..... 5-12-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 15 1947
BUREAU V S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-a

04433

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 18 years
 Hospital, institution, or street address where death occurred:
420 W. Church St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md. County Wash.
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 420 W. Church St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Daisy Ellen Smith

3. (b) Social Security Number

4. Sex <u>female</u>	5. Color or race <u>white</u>	6.(a) Single, married, widowed, or divorced <u>married</u>
6.(b) Name of husband or wife <u>Daniel Edward Smith</u>		
6.(c) If alive, give age <u>67</u> years		
7. Birth date of deceased (mo., day, yr.) <u>August 14, 1874</u>		
8. AGE: Years <u>62</u>	Months <u>8</u>	Days <u>25</u> If less than one day hrs. min.

9. Birthplace Foxville, Fred. Co., Md.
 (Town, county, and state)
 10. Usual occupation housewife
 11. Industry or business own home

FATHER	12. Name <u>Adam Forrest</u>
	13. Birthplace <u>unknown</u>
MOTHER	14. Maiden name <u>Ida Baker</u>
	15. Birthplace <u>unknown</u>

16. Informant Adam Smith
 Address Hagerstown, Md.

17. burial Date thereof 5-12-47
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Dunkard Cemetery
Beaver Creek, Md.
 Location
 18. Funeral director Scott F. Minnich & Son
 Address Hagerstown, Md.

19. May 10 47 Charles H. Powers,
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9, 1947 at 12:30 p.m.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 4, 1947 to May 9, 1947
 and that I last saw him alive on May 8, 1947
 Immediate cause of death
Clinic Myocarditis
 Due to Hypertension
 Due to myocarditis
 Other conditions
 (Include pregnancy within 3 months of death)

DURATION
<u>1 yr.</u>
<u>10 yr.</u>
<u>10 yr.</u>

Major findings of operations
 Date of op.
 Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide. Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

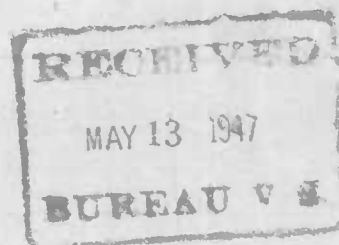
23. SIGNATURE Robert T. Thayer
 M. D. or other
 Address Hagerstown, Md. Date signed 5-10-47

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

04434

CERTIFICATE OF DEATH

Reg. Diat. No. 307

1. PLACE OF DEATH:

County WashingtonCity or town Trego Rural
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Trego LifeHospital, institution, or street address where death occurred: Trego md P.O.How long in hospital or institution? at How

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Washington County WashingtonCity or town Trego Rural
(If outside city or town limits, write RURAL and give nearest town)Street No. Trego P.O.
(If rural, give LOCATION)2.(a) If veteran, name war no.

3. (a) FULL NAME

George Seymour Smith

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife Clemmie Mullendore

7. Birth date of

deceased (mo., day, yr.)

August - 14 - 1861

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

It less than one day

85826

hrs.

min.

9. Birthplace

Rhensville Wash. Co. md.
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

FATHER
MOTHER

12. Name

Andrew R. Smith

13. Birthplace

Wash. Co. md.

14. Maiden name

Sarah Ann Thomas

15. Birthplace

Wash. Co. md.

16. Informant

Mrs. Edgar Mullendore

Address

Trego md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

May 13 1947
(month) (day) (year)

Cemetery or crematory

Rhensville Cemetery

Location

Rhensville md.

18. Funeral director

Wm J. Best & Son

Address

Boonsboro md.

19.

(Date rec'd by registrar)

19. 47

Mrs. Katherine Dugan
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May - 10 - 19. 47. at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 6 19. 47. to May - 10 19. 47.and that I last saw him alive on May - 10 19. 47.

Immediate cause of death

Cerebral Hemorrhage

DURATION

4 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Isabel Wade m.d.

M. D. or other

Address

Boonsboro, mdDate signed 5/11/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct age is especially important. Physicians; please write the causes of death clearly and legibly.

RECEIVED

MAY 16 1947

BUREAU V S

7-7-47 LL.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 30 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

George Washington Snively

3. (b) Social Security Number

705-10-5718

4. Sex

Male

5. Color or race

Negro

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Madeline Snively

7. Birth date of deceased (mo., day, yr.)

September 29, 1879

6. (c) If alive, give age

49 years

8. AGE:

Years 67 Months 7 Days 15 If less than one day

9. Birthplace

Beanes Creek, Md.
(Town, county, and state)

10. Usual occupation

Western Md. Railroad

11. Industry or business

Mrs. Snively

12. Name

Beanes Creek, Md.

13. Birthplace

Rachel Jackson

14. Maiden name

Beanes Creek, Md.

15. Birthplace

Mrs. Madeline Snively

16. Informant

114 W. North Street

17. Burial

Howell Hill Cemetery

18. Location

Hagerstown, Md.

19. Funeral director

William H. Osunny

20. Address

291 Frederick St. Hagerstown

21. Date

May 17, 1947

22. Registrar

Chas. H. Powers

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 114 W. North Street

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

5/14 1947 10:30

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 14 1947 to May 14 1947and that I last saw him alive on May 14 1947

Immediate cause of death

Coronary occlusionCardio-vascularDue to (?)

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op. 0Autopsy results 0

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide 0 Date of 0Where did injury occur? 0 (City or town) (County) (State)Injured at home, farm, industry, public place (where?) 0

Means of injury Injured at work?

Signature Victor D. Miller23. SIGNATURE VICTOR D. MILLER M. D. or otherAddress 131 W. WASHINGTON, ST.Date signed 5/15-1947

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Make correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 20 1947

BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Dr. Wells

CERTIFICATE OF DEATH

Reg. Dist. No. 04436 302

1. PLACE OF DEATH:

County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 20 Vale St.
(If rural, give LOCATION)2.(a) If veteran, name war None

3. (a) FULL NAME

MRS MARGARET ELIZABETH STRALEY

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife James H. Straley

7. Birth date of deceased (mo., day, yr.)

July 18, 19066. (c) If alive, give age 47 years

8. AGE:

Years

Months

Days

If less than one day

40106

hrs.

min.

9. Birthplace Westminister, Carrol Co. Md.
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Own Home12. Name George Weller13. Birthplace New Windsor Md.14. Maiden name Clara Ventz15. Birthplace Westminister Md.16. Informant James H. StraleyAddress Hagerstown Md.17. Burial Date there 5/27/47
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rest Haven CemeteryLocation Hagerstown Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. May 26, 1947 Charles H. Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24, 1947 at 3:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to 19.....

and that I last saw him alive on 19.....

Immediate cause of death

DURATION

acute cerebral hemorrhage

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations No

..... Date of op.

Autopsy results No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. Robert Wells DEPUTY MEDICAL EXAM.

WASH. CO., MD.

M. D. 5/26/47Address Hagerstown, Md. signed

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Write correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 28 1947

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH: County <u>Washington</u> City or town <u>Hagerstown</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>90 years</u> Hospital, institution, or street address where death occurred: <u>444 West Washington St.</u> How long in hospital or institution?				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>Maryland</u> County <u>Washington</u> City or town <u>Hagerstown</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>444 W. Washington</u> (If rural, give LOCATION) 2.(a) If veteran, name war			
3. (a) FULL NAME <u>Susan Catherine B. Strong</u>				3. (b) Social Security Number -----			
4. Sex <u>Female</u>		5. Color or race <u>White</u>		6. (a) Single, married, widowed, or divorced <u>Widowed</u>			
6. (b) Name of husband or wife <u>Samuel M. Strong</u>							
7. Birth date of deceased (mo., day, yr.) <u>Aug 18, 1850</u>							
8. AGE: Years <u>96</u>		Months <u>9</u>		Days <u>1</u>			
If less than one day _____ hrs. _____ min.							
9. Birthplace <u>Franklin Co. Pa.</u> (Town, county, and state)							
10. Usual occupation <u>None</u>							
11. Industry or business <u>None</u>							
FATHER 12. Name <u>Samuel Binkley</u>							
13. Birthplace <u>State Line Pa.</u>							
MOTHER 14. Maiden name <u>Susan Snively</u>							
15. Birthplace <u>Near Greencastle Pa.</u>							
16. Informant <u>Emma J. Strong</u> Address <u>Hagerstown Md.</u>							
17. Burial (Burial, cremation, or removal. Which?) <u>5-22-47</u> (month) (day) (year) Cemetery or crematory <u>Rose Hill Cemetery</u> <u>Hagerstown Md.</u> Location <u>Scott F. Minnich & Son</u> <u>Hagerstown Md.</u>							
18. Funeral director <u>Scott F. Minnich & Son</u> Address <u>Hagerstown Md.</u>							
19. May 22, 47 (Date rec'd by registrar) Registrar <u>W. H. Flowers</u>							
MEDICAL CERTIFICATION 20. DATE OF DEATH <u>May 19 47</u>							
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>Jan. 4</u> <u>47</u> to <u>May 19</u> <u>47</u> and that I last saw him alive on <u>May 19</u> <u>47</u> Immediate cause of death: <u>Acute Cor. Pulm.</u> <u>Acute Pulmonary edema due to</u> <u>myocardial infarction, evidently due to</u> <u>hypertrophy of left ventricle</u> Due to <u>Sp. A. H. T.</u> Due to _____ Other conditions _____ (Include pregnancy within 3 months of death) Major findings of operations _____ Date of op. _____ Autopsy results _____ PHYSICIAN: Please underline the cause to which death should be charged statistically.							
22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide _____ Date of _____ Where did injury occur? _____ (City or town) _____ (County) _____ (State) Injured at home, farm, industry, public place (where?) _____ Means of injury _____ Injured at work? _____							
23. SIGNATURE <u>W. H. Flowers</u> Address <u>Hagerstown Md.</u> Date signed <u>5-20-47</u>							

04437

79

RECEIVED

MAY 24 1947

BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Conrad

04438

Reg. Dist. No. 305

1. PLACE OF DEATH:

County Washington
 City or town Breathedsixville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 month
 Hospital, institution, or street address where death occurred:
Md. State Reformatory for Males
 How long in hospital or institution? 1 month

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Virginia County Fairfax
 City or town Alexandria
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1519 King St
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

JAMES LEO TAYLOR

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Divorced
 6.(b) Name of husband or wife ---
 6.(c) If alive, give age - years
 7. Birth date of deceased (mo., day, yr.) May 14 1910
 8. AGE: Years 37 Months - Days 1 If less than one day hrs. min.

9. Birthplace Alexandria Fairfax Co. Va.
 (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Laborer

12. Name James A. Taylor

13. Birthplace Alexandria Va.

14. Maiden name Catherine Williamson

15. Birthplace Alexandria Va.

16. Informant James A. Taylor

Address Alexandria Va.

17. Burial Date thereof 5/17/47
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington Cemetery

Location Arlington Virginia

18. Funeral director Andrew K. Coffman

Address Hagerstown Md.

19. May 16, 1947 John H. Bast
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15 1947 19 5 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 19 47 to May 15 19 47
 and that I last saw him alive on 5-15 19 47

Immediate cause of death Pulmonary tuberculosis

DURATION

6 months

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert P. Conrad, M.D. M. D. or other

Address Hagerstown, Md Date signed 5-16-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 22 1947

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131 f

04439

CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH:

County WashingtonCity or town Boonsboro
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 50 years

Hospital, institution, or street address where death occurred:

Boonsboro Md
How long in hospital or institution? at home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Boonsboro
(If outside city or town limits, write RURAL and give nearest town)Street No. Boonsboro Md
(If rural, give LOCATION)

2. (a) If veteran, name war

No.

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

malenegromarried

6. (b) Name of husband or wife

Elizabeth Joy

6. (c) If alive, give age. years

7. Birth date of deceased (mo., day, yr.)

May - 9 - 1870

8. AGE:

Years

Months

Days

If less than one day

761124

hrs.

min.

9. Birthplace Middletown, Fred. Co. Md.
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

FATHER

12. Name

Samuel Joy

13. Birthplace

Fred. Co. Md.

MOTHER

14. Maiden name

Amy

15. Birthplace

Fred. Co. Md.

16. Informant

Mrs. Elizabeth Joy

Address

Boonsboro Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

May - 5 - 1947
(month) (day) (year)

Cemetery or crematory

Boonsboro Cemetery

Location

Boonsboro Md.

18. Funeral director

Con J. Best & Sons

Address

Boonsboro Md.

19.

May - 5 - 1947
(Date registered by registrar)

19.47

John H. Best

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May - 2 - 1947 at 10:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

February 8 - 1947 to May 2 - 1947and that I last saw him alive on May 1 - 1947

Immediate cause of death

Chronic Nephritis

DURATION

2 hrs 24 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John H. Best - M. D.

M. D. or other

Address

Boonsboro Md.Date signed 5/3/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Write correct age in correct age. is especially important. Physicians: please write the causes of death clearly and legibly.

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MAY 8 1947

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

04441

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1/2 day

Hospital, institution, or street address where death occurred:

Washington Co. HospitalHow long in hospital or institution? 1/2 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hancock
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

William Henry Ward

3. (b) Social Security Number

705-05-9178

4. Sex

Male

5. Color or race

White

8. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Goldie Stoner Ward

7. Birth date of

deceased (mo., day, yr.)

Sept. 22, 1881

8. AGE:

65 Years8 Months0 Days

If less than one day

— hrs. — min.

9. Birthplace

Fulton Co., Penna.

(Town, county, and state)

10. Usual occupation

Retired Railroader

11. Industry or business

FATHER

12. Name

Simon Ward

13. Birthplace

Robinsonville, Bedford Co., Penna.

MOTHER

14. Maiden name

Sarah Flowers

15. Birthplace

Virginia

16. Informant

Mrs. Geneva Hobday

Address

Berkeley Springs, W. Va.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereon

May 25, 1947

Cemetery or

Buck Valley Methodist

Location

Buck Valley, Fulton Co., Penna.

18. Funeral director

Charles R. Bast

Address

Hancock, Md.

19. (Date rec'd by registrar)

May 24, 47

19. (Date rec'd by registrar)

Wm. H. Powers

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 22, 1947 at 2:02 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19....., 19....., 19.....

and that I last saw him.....alive on.....19.....

Immediate cause of death

DURATION

Perforated intestinal ulcerDue to In ileum 30 inches fromileocecal valve)

Due to

acute peritonitis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

.....Date of op.

Autopsy results as above May 22, 1947

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

S. Robert Wells May 23/47

DEPUTY MEDICAL EXAM.

Vol. 10M. D. Wells

Address

Hagerstown, Md.

Date signed

May 23/47

RECEIVED

MAY 27 1947

BUREAU V.B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Bowman

114442

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 Days
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 2 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State West Virginia County Mineral
 City or town Keyser
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. E. Armstrong St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war None ✓

3. (a) FULL NAME

KEITH BELMONT WELCH JR.

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife --
 7. Birth date of deceased (mo., day, yr.) May 7, 1947
 8. AGE: Years -- Months -- Days 2 If less than one day hrs. min.

9. Birthplace Hagerstown Washington Co. Md.
 (Town, county, and state)

10. Usual occupation --

11. Industry or business --

FATHER 12. Name Keith Belmont Welch

13. Birthplace Keyser W. Va.

MOTHER 14. Maiden name Floretta Shirley

15. Birthplace Martin W. Va.

16. Informant Keith B. Welch

Address Keyser W. Va.

17. Burial Burial Date thereof 5/10/47
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown Md.

18. Funeral director Andrew K. Coffman

Address Hagerstown Md.

19. May 10, 47 Registrar Blanch Bowers
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9, 19 47, at 11:30

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/7 19 47, to 5/9 19 47
 and that I last saw him alive on 5/9 19 47

Immediate cause of death atelectasis Bilateral

Due to prematurity

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results atelectasis - Bilateral - complete

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H.D. Bowman
 Address Hagerstown, Md. Date signed 5/10/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MAY 13 1947

BUREAU OF

Evidence for addition of birthdate
shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

181

FILM No. G 110 JUN 4 1947 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County... Washington
City or town... Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
Hospital, institution, or street address where death occurred:
Washington County Hospital
How long in hospital or institution? 18 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Washington
City or town... Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1112 Pope Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Glenda B. Weller

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, year) April 7, 1934

8. AGE: 13 Years Months Days If less than one day hrs. min.

9. Birthplace Hancock, Md.
(Town, county, and state)

10. Usual occupation School Student

11. Industry or business

12. Name Resley H. Weller

13. Birthplace Hancock, Md.

14. Maiden name Vesta Keefer

15. Birthplace Hancock, Md.

16. Informant Resley H. Weller

Address 1112 Pope Avenue- Hagerstown, Md.

17. Burial Date thereof May 20, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rehobeth Cemetery

Location Near Hancock, Md.

18. Funeral director Snyder-Rowland Funeral Home

Address Hancock, Md.

19. May 20, 47 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION E.D.S.T.

20. DATE OF DEATH May 17, 1947 19:1:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19..... to 19..... and that I last saw him..... alive on 19.....

Immediate cause of death.....

2nd&3rd degree burns
over entire body
toxemia

DURATION

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... None

Date of op.

Autopsy results..... None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 5/16/47

Where did injury occur? Hagerstown Wash. Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury... Injured at work? no

23. SIGNATURE H. Robert Wells

Address Hagerstown, Md. Date signed 5/19/47

DEPUTY MEDICAL EXAM.

WASH. CO., MD.

M. D. or other

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 22 1947

BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

181

04443

73

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years
 Hospital, institution, or street address where death occurred:

Washington County Hospital
 How long in hospital or institution? 12 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 1112 Pope Avenue
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Lester Garry Weller

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) April 25, 1944 6.(c) If alive, give age _____ years

8. AGE: Years 3 Months 0 Days 22 If less than one day _____ hrs. _____ min.

9. Birthplace Hagerstown- Washington- Md.
 (Town, county, and state)

10. Usual occupation None

11. Industry or business

12. Name Resley H. Weller13. Birthplace Hancock, Md.14. Maiden name Vesta Keefer15. Birthplace Hancock, Md.16. Informant Resley H. WellerAddress 1112 Pope Ave.-- Hagerstown, Md.

17. Burial May 20, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rehobeth CemeteryLocation Near Hancock, Md.18. Funeral director Snyder-Rowland Funeral HomeAddress Hancock, Md.

19. May 20, 47 Chas Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION E.O.J.T.20. DATE OF DEATH May 17, 1947 6:40 A. M. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19____, to _____ 19____

and that I last saw him _____ alive on _____ 19____

Immediate cause of death _____

2nd degree burns to face 12 hrDue to shoulders & upper armsDue to acute edema of lungs

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. _____

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 5/16/47Where did injury occur? Hagerstown (City or town) Wash (County) Md (State)Injured at home, farm, industry, public place (where?) HomeMeans of Injury Explosion of pt Injured at work? NoDEPUTY MEDICAL EXAM: J. Parker Wells WASH. CO., MD.23. SIGNATURE J. Parker Wells M. D. or otherAddress Hagerstown, Md. Date signed 5/19/47

RECEIVED
MAY 22 1947
BUREAU OF S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

462

04445

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 15 years
 Hospital, institution, or street address where death occurred:
722 Oak Hill Avenue
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 722 Oak Hill Avenue
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Ardella McDonald Willis

3. (b) Social Security Number

none

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow
 6. (b) Name of husband or wife Clarence E. Willis
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) November 22, 1890
 8. AGE: Years 56 Months 6 Days 2 It less than one day _____ hrs. _____ min.

9. Birthplace Jefferson Co. W. Va.
 (Town, county, and state)
 10. Usual occupation Housework
 11. Industry or business

FATHER 12. Name Robert Vincent McDonald
 13. Birthplace Jefferson Co. W. Va.
 MOTHER 14. Maiden name Anna Maxine West
 15. Birthplace Jefferson Co. W. Va.

16. Informant Miss Jane Willis
 Address Hagerstown, Maryland
 17. Burial Edge Hill Cemetery Date thereof 5-26-47
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Charlestown, W. Va.
 Location

18. Funeral director C. M. Suter & Sons
 Address Hagerstown, Maryland

19. May 26, 1947 Charles Powers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24 19 47 at 6:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 9 19 47 to May 24 19 47
 and that I last saw him alive on May 23 19 47

Immediate cause of death Carcinoma Transverse Colon with Extension to Sigmoid
 Due to to lines DURATION 1943

Due to
 Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations as above
 Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work?

23. SIGNATURE H. H. Porterfield M.D.
 M. D. or other
 Address 136 W Washington Date signed 5/24/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MAY 28 1947
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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
Hagerstown
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 year
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 12 years 4 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 610 Summit Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Carl S. Wittmer Sr.

3. (b) Social Security Number

179-20-5574

4. Sex Male 5. Color or race White 8.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Sarah J. Wittmer

6.(c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) April 10, 1878

8. AGE: Years 69 Months 1 Days 6 If less than one day hrs. min.

9. Birthplace Marrietta Lan. Pa.
 (Town, county, and state)

10. Usual occupation Retired

11. Industry or business York Trust Co.

12. Name Jacob L. Wittmer

13. Birthplace Washington Borough Pa.

14. Maiden name Annie C. Summy

15. Birthplace Marrirtta Pa.

16. Informant Carl S. Wittmer Jr.

Address Hagerstown Md.

17. Burial Date thereof 5-19-47
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Greenmount Cemetery

Location York Pa.

18. Funeral director Scott F. Minnich & Son

Address Hagerstown Md.

19. May 16, 1947 Registrar Charles H. Bowers

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16, 1947 at 1:10a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 5, 1947 to May 16, 1947 and that I last saw him alive on May 16, 1947

Immediate cause of death Cerebral hemorrhage

Due to Arterio sclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Antopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [Signature] M. D. or other
 Address [Signature] Date signed

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MAY 19 1947
BUREAU 98

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Paramount, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
Paramount, Maryland
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Paramount
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Rural #4
 (If rural, give LOCATION)
 2.(a) If veteran, name war World War #1

3. (a) FULL NAME

William Cook Wolfinger

3. (b) Social Security Number

215-26-2258

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Margaret M. Wolfinger
 6.(c) If alive, give age 45 years
 7. Birth date of deceased (mo., day, yr.) May 1, 1898

8. AGE: Years 49 Months 0 Days 4 If less than one day
 hrs. min.

9. Birthplace Hagerstown, Wah. Co. Md.
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

12. Name Scott M. Wolfinger
 13. Birthplace Hagerstown, Maryland

14. Maiden name Mary A. Spielman
 15. Birthplace Hagerstown, Maryland

16. Informant Mrs. William C. Wolfinger
 Address Paramount, Maryland

17. Burial Date thereof 5-7-47
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery
 Location Hagerstown, Maryland

18. Funeral director C. M. Suter & Sons
 Address Hagerstown, Maryland

19. May 6, 1947 Frank Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5, 1947 at 3:30 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from EDSV
 19 to 19
 and that I last saw him alive on 19

Immediate cause of death

Acute coronary occlusion DURATION 2 hrs.

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results NO

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide NO Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

22. SIGNATURE H. R. Phillips M. D. another

Address Hagerstown, Md. Date signed May 5 '47

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MAY 8 1947
BUREAU 13

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. R. M. Campbell 46

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 Weeks
Hospital, institution, or street address where death occurred:
Washington County Hospital
How long in hospital or institution? 3 Weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1104 Hamilton Blvd.
(If rural, give LOCATION)
2.(a) If veteran, name war None

3. (a) FULL NAME

MRS ANNA WARNOCK YOUNG

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Stephen
6.(c) If alive, give age 60 years
7. Birth date of deceased (mo., day, yr.) March 30, 1870
8. AGE: Years 77 Months 1 Days 4 If less than one day -- hrs. -- min.

9. Birthplace Pittsburgh Allegany Co. Pa.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Own Home
12. Name No Record
13. Birthplace No Record
14. Maiden name No Record
15. Birthplace No Record

16. Informant Mrs. Marie W. Eldridge
Address Hagerstown Md.

17. Burial Burial Date thereof 5/7/47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Ross Hill Cemetery
Location Hagerstown Md.

18. Funeral director Andrew K. Coffman
Address Hagerstown Md.

19. May 5, 1947 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4, 1947 19 47 11:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 7, 1947 to May 4, 1947
and that I last saw h.E.R. alive on May 4, 1947

Immediate cause of death Pneumonia, terminal
Bilateral DURATION 1 wk.

Due to

Due to

Other conditions Gen'l. Arteriosclerosis
Fracture left hip
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of April 15, 1947

Where did injury occur? 1104 Hamilton Blvd.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) 1104 Hamilton Blvd.

Means of injury slipped on rug and fell Injured at work?

23. SIGNATURE Robert V. P. Campbell M.D.
Address Hagerstown Md. Date signed 5/5/47

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Write correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 7 1947

BUREAU 16